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ABSTRACT

This report describes a project which surveyed providers and purchasers of nursing services within the National Health Service in England on what is available and what is needed in staff training for those working with individuals having mental retardation and challenging behaviors and/or mental illness. Section 1 describes the methodology of the study and reviews the literature. Section 2 reports the perceptions of 70 nursing college providers and 55 purchasers concerning definitions, models of service provision, and required skills and standards for staff working with this client group. Section 3 is a directory of 12 existing, externally validated courses. Provided for each listing is the title; coordinator's name; name of institution; and a summary (such as course length, format, target student group, admission requirements, award, content, and validation). Short courses and workshops are also listed, as is information on courses planned by survey respondents. Recommendations focus on development of a National Resource Group of educators, managers, and users; key emphases of training; and clarification of terminology. The questionnaire forms are appended. (Contains 60 references.) (DB)

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ED 392 181

LEARNING DISABILITIES AND CHALLENGING BEHAVIOUR

Training staff to work with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness

FINAL REPORT

of a project funded by the English National Board

M Clifton and J Brown with V Naylor

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We would particularly like to thank Vanessa Naylor, who carried out the groundwork to the project in its early stages and brought her insight and good humour to the research team. Members of the Steering Group contributed to the project development with their considerable experience and expertise.

Responsibility for the views expressed, issues of interpretation, questions of inclusion and omission, remain as always with the research team and do not necessarily reflect the views of the English National Board for Nursing, Midwifery and Health Visiting.

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INTRODUCTION

The passing and current implementation of the NHS and Community Care Act, 1990, embodies a radical redefinition of administrative responsibilities and organizational structures in health and social care. The pace and volume of change associated with this redefinition is probably unprecedented since the NHS was established in the late 1940s. Even five years ago it would have been difficult to anticipate fully the range of changes now taking place. These changes have affected all aspects of health care, including nursing and nurse education.

Project 2000 (UKCC, 1986) had emerged from debates within the nursing profession held in the early 1980s. By the time it was accepted by the Government and implemented on a demonstration basis at the end of the 1980s the context in which nurse education was to be delivered had changed dramatically. Schools of Nursing had been replaced by Colleges of Nursing and Midwifery/Health Studies and links with higher education had been established and consolidated. Often, Colleges that were barely established in their own right became merged with neighbouring colleges. The upheaval was, and is, considerable. At the same time the relationship between education and service became subsumed respectively under the introduction of providers and purchasers. The terminology of the market and the contract culture has become dominant. The impact has been considerable, and is reflected in the importance attached to management.

Since the Griffiths management inquiry was submitted to DHSS in 1983 the general manager has come to pervade all levels of the NHS. It can no longer be assumed that, for example, nurse education in the new colleges of nursing and midwifery/health studies will be ultimately the responsibility of nurse educationalists. The introduction of contracts for nurse education has involved Regional Health Personnel Departments in ways that would not have been possible before the introduction of the National Health Service and Community Care Act, 1990 (DH, 1989c). Workforce planning, or increasingly Human Resource Management, is developing a momentum as a management tool in the planning of service delivery that could not have been anticipated from the more traditional approaches to manpower planning. The climate in which initiatives such as Post Registration Education and Practice (UKCC, 1990) are received and evaluated has changed irrevocably.

It was against this background of considerable change not just within nursing but across all aspects of health and social care that the present project evolved. The particular focus was upon one area of activity of the nurse in learning disabilities - namely, the work with those clients exhibiting challenging behaviour and associated mental illness. The term 'learning disabilities' has been adopted (in preference to 'mental handicap') in view of its use in Government policy (Dorrell, 1991).

The Evolution of the Protocol

Work with those who exhibit learning disabilities is a low-status activity regardless of the person's professional background. Nursing is no exception. The Platt Report published by the Royal College of Nursing (RCN) in 1966 expressed confusion and uncertainty over the role of the mental subnormality nurse. The reception given to the Jay Report (DHSS, 1979) by mental handicap nurses, as mental subnormality had become, did little to resolve a debate that had become polarised into nurse versus social worker, hospital versus community. While the issues were never as clear cut as this it was only with publication in 1989 of the White Paper on community care, Caring for People, that lead responsibility for community care was formally accorded to social services departments by central government.

A future role of the nurse in learning disabilities was acknowledged but the details were left unspecified. Two years later, in 1991, a report commissioned by the four Chief Nursing Officers in the United Kingdom, the Cullen Report (CNOs, 1991), argued for a role for the nurse across the health and social care spectrum. In particular, emphasis was placed upon work with those exhibiting challenging behaviour where, it was argued, the nurse in learning disabilities had a particular contribution to make. This became the focus of the protocol. As the White Paper emphasised the importance of inter-disciplinary training between all professions, which was backed up by subsequent publications from the DH (e.g. DH/SSI, 1991), it was felt that the protocol had to reflect this perspective. This was particularly appropriate in learning disabilities because, in spite of the antipathy felt between nursing and social work, especially after the Jay Report, it is the client group where work on shared/joint training has progressed further than for any other group.

Initial work concentrated, therefore, on evaluating two post-registration courses on challenging behaviour that were validated jointly by the English National Board for Nursing, Midwifery and Health Visiting (the Board) and the Central Council for Education and Training in Social Work (CCETSW), one in Bristol the other in Manchester. The objective was to identify lessons in establishing and running such courses that could be drawn upon by other centres and to identify the components of an appropriate package for work in this area. Once the work proceeded it became apparent that such an approach was not as relevant as initially anticipated due to the changes taking place within the NHS.

Both course centres had difficulty recruiting students. In spite of their national reputations and prominence local managers were reluctant to second staff to such courses. Of greater concern was arranging courses run locally that were seen as 'owned' by managers and possibly more relevant to local concerns. Such courses were emerging in an ad hoc uncoordinated manner. With changes in the role of the Board about to be introduced in 1993 it was decided, with full consultation with the Steering Group, to change the emphasis of the protocol so that it more accurately reflected current concerns.

The lead for the change in emphasis was taken from the work done for the Board by Learning Materials Design (LMD) on children's nursing. In their report of the various events they arranged for children's nurses they comment that:

> "...participants did not look to the Board for a revised and updated package for students. Instead, they sought means to support the critical selection and use of resources in teaching and learning, and the sharing of ideas about teaching and learning, in the field of children's nursing." (ENB, 1991, p.7).

The Board was seen as having a more facilitative rather than prescriptive role for the future. This provided the direction for the protocol upon which the challenging behaviour project developed. The objectives became:

a) to gauge the opinions of both providers and purchasers within the NHS in England on what was required in staff training for those working in the area of challenging behaviour, with particular reference to associated mental illness.

b) to construct a directory of courses currently available or planned for the near future in this area.

c) to make recommendations.

The report is divided into four sections.

The Structure of the Report

Section I, Methodology and Literature Review consists of four chapters. The first is an account of the methods used in the project along with the response rates to each request for information. The outcomes of Phase 2 and their influence on the development of Phase 3 are also reported. Chapter 2 provides a brief account of the policy context within which the provision of training takes place. Chapter 3 presents information on problems of definition of challenging behaviour and the diagnosis of mental illness, in people with learning disabilities. In Chapter 4 some therapeutic responses to challenging behaviour are described and models of service provision for meeting the needs of people with learning disabilities, challenging behaviour and mental illness.

Section II, Perceptions of Providers and Purchasers includes two chapters on the responses of providers and purchasers of training. Chapter 5 includes material on definitions, service models and the use of and views about training for staff working with this client group. Chapter 6 includes material on the required skills for meeting their needs and views on standards of competence on the part of course participants and of course comparability.

In Section III, Directory of Courses, information on the various post-registration courses in challenging behaviour, predominantly offered by Colleges of Health/Nursing, is presented.

Finally, in Section IV, Taking the Initiative, the main conclusions are presented, along with a number of recommendations on possible future involvement of the Board in this area of training. A summary of the recommendations precedes Section I.

SUMMARY OF RECOMMENDATIONS

1. The annual English National Board conference on Mental Handicap/Learning Disabilities Nursing to be developed as the basis for a 'National Resource Group' embracing educators, managers and users.

2. The 'National Resource Group' to provide a pivot for a network involving activities broader than an annual conference and conference report.

3. Detailed implementation notes on applying the Framework of the Higher Award to challenging behaviour to be drawn up and widely circulated.

4. Particular emphasis to be placed on three of the ten characteristics - specialist skills, flexible and innovative approaches, and role models.

5. Guidance and clarification to be provided on a variety of terms to ensure common usage:

    joint/shared training and shared learning
    challenging behaviour
    challenging behaviour and mental illness
    challenging behaviour, mental illness and learning disability

SECTION I

Methodology and Literature Review

CHAPTER 1

METHODS AND RESPONSES

Introduction

This exploratory project was carried out in three phases, and evolved as concerns changed and the outcomes for each phase were assessed.

In this chapter the methods whereby information was collected for Phases 1, 2 and 3 are described. These methods included library research, general requests for information from purchasers and providers of training, interviews and a postal survey of purchasers and providers of training.

The number and nature of responses to the various requests for information are also reported, along with the outcomes of Phase 2 which informed the design and methods of Phase 3.

1 Phase 1 - Definitions and Directory

As the project progressed, so the objectives of the research evolved. The focus of Phase 1 moved away from the evaluation of specific courses to a more detailed literature search and analysis of the policy and service issues in respect of people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness. Work was also started on the development of a Directory of Training Courses for staff working with this specific client group.

2 Literature search

A literature search was conducted to identify policy documents, issues around the definition of challenging behaviour and policy for service provision. Arising from this work emerged

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the need to pursue a further literature search to identify work on the inter-relationships between learning disabilities, challenging behaviour and mental illness and current awareness of those interrelationships. A further literature search identified recent literature on therapeutic approaches to meeting the needs of this client group. The results of this work are reported in the remainder of Section II, which includes chapters on:

a) policy issues which provide the context for the remainder of the research findings;

b) definitions of challenging behaviour and issues around the recognition of mental health problems in people with learning disabilities;

c) a number of therapeutic approaches to meeting the needs of people with learning disabilities who exhibit challenging behaviour, and the various models of service provision.

2.1 The directory

During Phase 1, work was started on the initial stages of developing a directory of training courses for staff, particularly registered nurses, but with an additional focus on jointly validated courses for nursing and social work staff. In addition to challenging behaviour exhibited by people with learning disabilities, training courses which addressed the issue of associated mental illness were of special interest.

2.1.1 Information from the English National Board A list of colleges which had received approval to offer relevant courses was provided by the Board. These courses included:

a) ENB validated courses which specifically include a reference to challenging behaviour and learning disabilities:

No 2 Understanding and Working with Challenging Behaviour;

705 Behaviour Modification in Mental Handicap Nursing;

937 Behaviour in Mental Handicap Nursing for Registered and Enrolled Nurses.

b) the total list of ENB validated courses, including courses in which an element on challenging behaviour and associated mental illness in people with learning disabilities might be provided.

Those colleges which were approved to run courses identified in a) above were included in the Directory at this stage, along with ENB courses A12 (Cognitive Behaviour Therapy) and 939/933 (Care of People with a Mental Handicap/Mental Illness in Community Residential and Day Care Services).

2.1.2 Information received from trawl of Regional Health Authorities (RHAs) A letter was sent to the 14 Regional Nurse Training & Education Officers in December 1991, seeking information about existing training initiatives for staff working with this client group. Responses to this letter are set out in Table 1.1.

Table 1.1: Directory of Training Courses: RHA responses

Response	N
Replied direct	4
Our letter forwarded to colleges	3
Addresses sent for us to contact	1
No reply	6
Total	14

Nearly half the regions did not reply and those who did variously replied direct, forwarded our letter on to colleges and/or provider units and, in one case, sent addresses of colleges, continuing education departments within provider units and provider units for us to contact direct.

Where the information had been sought from other contacts in the regions (colleges, provider units or continuing education department), whether directly or indirectly, the following responses were received:

Table 1.2: Directory of Training Courses: Other responses

Responded	No response	Total
5	1	6
3	NI	NI*
2	2	4
8	12	20

* This region forwarded our letter on to colleges, but did not inform us as to how many had been asked to send us information so we have no way of knowing how many, if any, had not responded to us.

2.1.3 Other sources of information about training

Other courses have been identified from literature reviews, conference attendance and personal contacts, as well as the major national organisations offering training in the general field of learning disabilities.

By these means, information was sought from the following:

BILD (British Institute for Learning Disabilities, formerly British Institute for Mental Handicap (BIMH);
CCETSW;

Richmond Fellowship;
University of Birmingham;
University of Kent;
Castle Priory College;
the Lodden School;
MIETS (Mental Impairment Evaluation and Treatment Services Unit, The Bethlem Royal Hospital);
Association for Psychological Therapies;
In-service training offered by the Dept. of In-service Training at a DHA;

The BILD were unable to provide information about their courses in respect of this specific client group as they were in the process of reorganising their existing courses and developing new ones to meet this need. The Richmond Fellowship training programme offered a number of courses on behavioural difficulties and many on mental health problems, but none were related to the needs of people with learning disabilities. Consequently, these courses have not been included in the Directory. The CCETSW information included a number of courses specifically in relation to this client group. Where Colleges of Nursing and Midwifery/Health Studies have provided courses validated by CCETSW these have been identified as such in the Directory. Courses provided by the DHA Department of In-service Education have however been included. It was never the intention to carry out a systematic survey of in-service training provision, but these have been included as an example of the sort of courses such provision might include.

2.1.4 Findings The information collected as a result of this work is contained in the Directory of Training Courses included as Section III of this report. This Directory has concentrated primarily on courses offered by Colleges of Nursing and Midwifery/Health Studies although courses provided by some other agencies are included, as examples of alternative provision of training.

2.2 Semi-structured interviews and discussion groups

As part of the exploratory work for Phase 1, discussions were held with a small number (6) of middle managers responsible for the provision of services for people with learning disabilities, who exhibit challenging behaviour. As a result of these discussions some insights into the issue of identifying training needs emerged, along with additional perspectives on the questions of mental illness and challenging behaviour in people with learning disabilities. These discussions also informed the development of Phase 3, and the key points in this regard are reported below (p. 9).

3 Phase 2 - Training Needs

The purpose of Phase 2 was to carry out a feasibility study to identify the key issues in relation to staff training needs in relation to this client group. The second main task carried out in this project, therefore, involved an inquiry into Regional Health Authority views on the identification and meeting of training needs of staff working with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness.

3.1 Methods

Letters were sent to the Directors of Nursing and Directors of Personnel at the fourteen English RHAs in January 1992. In this letter, information was sought on the following:

> regional (and district) policy on skills needed to meet the needs of this client group;
>
> in particular, views on the "post-registration training needs of those who work with challenging behaviour and mental illness"

Again responses have been varied, as Table 1.3 indicates.

Table 1.3: Training needs: RHA responses

	Replied	NR	Total
a) Directors of Personnel:	5*	9	14
b) Directors of Nursing:	8	6	14
Total	13	15	28

*Includes one who wrote to say our letter had been passed on to a third party, from whom there has been no reply.

Of the 28 letters sent out, there has been no reply from just over half. Analysed by RHA, there have been replies from both Directors in 4 Regions, from the Director of Nursing only in 4 Regions, from the Director of Personnel only in 1 Region and no reply at all from the remaining 5 Regions.

3.2 **Semi-structured interviews**

Arising from the letters to RHAs semi-structured interviews were held with two people - one a manager of a local service for people with learning disabilities and challenging behaviour, and the other a provider of training in the Continuing Education Department of a District Health Authority. Material collected from these interviews helped to confirm the direction proposed for Phase 3, and the key issues facing service providers. Some of the information and opinions collected during Phase 1 also added insights to the nature of the issues to be addressed in Phase 3.

The outcome of this work is reported next, to indicate how the work of Phase 2 informed the development of Phase 3.

3.3 **Identifying training needs - outcomes**

Substantive responses to the request for information were received from 12 Directors of Personnel or of Nursing. The main point/issues raised by these respondents are reported next.

a) There was a general recognition that this is an area of **special interest** and difficulty - although not all regions were in a position to report on developments at present. This was an issue they were planning to deal with and various mechanisms were mentioned - including the appointment of specialist nurse advisors in the fields of mental health and of learning disabilities, or the existence of joint working groups of service providers/nurse educators;

b) it was stressed by a number of respondents that the continuing education strategy should be responsive to **local service needs** - and therefore that identification of staff training needs and provision to meet those needs should be locally based and locally managed. Several regions suggested we contact Trusts and Provider Units for specific and detailed information.

c) Staff training to meet the needs of this specific client group must be **collaborative**. There were several references to jointly validated (ENB and CCETSW) courses, both at pre-qualification Registered Nurse, Mental Handicap (RNMH) and Diploma in Social Work, (DipSW) level and at post-qualification level. Particular mention was made of the lack of clarity in the distinction between health and social needs in clients with a learning disability. The existence of challenging behaviour was specified in relation to health care needs by more than one authority, although these clients would also have social care needs.

d) One region made specific reference to the desirability of **dual registration** - in particular to a need for staff with both RNMH and RMN, and with considerable experience in both fields. A suggestion for common training between mental health and learning disability was noted by another respondent.

Discussions with middle managers confirmed the importance of these issues, particularly the reference to collaborative work in training, and with meeting the needs of local services. Two additional concerns arose from these discussions, namely:

a) the **specific skills** sought from staff working with this client group - it was felt that there was an over-emphasis on behavioural techniques in training for staff working with this client group and that a wider range of skills, appropriate to the needs of particular individuals and specific to local services should be the focus of staff training;

b) the setting of **standards of competence** - both within courses and between courses. The latter issue is of particular importance if training has a very local focus, specific to the needs of particular individuals. In these circumstances the question arises of how training can be portable from one service to another if staff move on.

The recommendation for a postal survey of providers and purchasers of training emerged as a result of this feasibility work. The content of the questionnaires, in particular the open-ended questions were guided by the responses from the RHAs, and from the discussions and informal interviews with local services managers.

4 Phase 3 - Survey of providers and purchasers of training

As a result of the material emerging from Phase 1 and from the feasibility study of Phase 2, the objectives of Phase 3 were defined as:

a) to collect more comprehensive information about the training offered by Colleges of Nursing and Midwifery/Health Studies for staff working with people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness;

b) to collect and report the views of both providers of training (Colleges of Nursing and Midwifery/Health Studies) and purchasers of training (service providers and managers) within the NHS in England about the issues arising from the work of Phases 1 and 2;

c) to make recommendations.

The detail of the methods is described in the next section.

4.1 Postal survey

Two postal questionnaires were designed - one for Colleges of Nursing and Midwifery/Health Studies and one for service managers.

4.1.1 Mailing lists The mailing list for the Colleges was provided by the Board, who sent addresses for 135 Colleges of Nursing and Midwifery/Health Studies. The questionnaire was not sent to Colleges in Guernsey, Jersey and Gibraltar, and from the replies received a further three were deleted from the baseline as Colleges had merged since the list had been drawn up. The final baseline therefore was 129 Colleges. A covering letter explained the purpose of the survey and indicated that this exercise represented an opportunity for respondents to make their views known to the Board.

The mailing list for the service managers/purchasers of training was more difficult to identify. The original plan had been to approach NHS and independent sector service providers, and Colleges of Nursing and Midwifery/Health Studies were asked to identify any independent sector purchasers of training with whom they worked. In the event none were so identified, so the data from purchasers is limited to information from NHS service providers. Identifying these providers took longer than had been anticipated. The strategy was to target managers of services for people with learning disabilities direct rather than sending the questionnaire to general managers with a request for them to forward this on to the appropriate person in the expectation that this would speed up the process of response. Unfortunately, given the rapid and major organisational changes which the NHS is undergoing, this proved to be a time-consuming task. The logistical problems in relation to this aspect of the research were two-fold, namely:

a) as a result of the NHS reforms and the establishment of the first and second wave of NHS Trusts in April 1991 and 1992 respectively, there was no published list of NHS provider units which incorporated the second wave of Trusts. Several avenues were explored before a complete list of NHS Trusts was acquired;

b) identifying from the combined lists of Trusts and District Health Authorities (the latter published in the Hospitals and Health Service Yearbook, 1991) the relevant addressees with responsibility for services for people with learning disabilities. From the lists of Trusts it was clear that some were not relevant - primarily where the Trust name specified particular acute hospital services. Many Trust names identified only general services, such as community or priority services, and others had names which gave no indication of the patient or client group at all. Consequently, time was spent checking the Trust lists against the published information about DHAs.

In the event, a total of 142 questionnaires were sent direct to managers of learning disability services - 93 to Directly

Managed Units (DMUs) and 49 to NHS Trusts. A further 41 were sent to District General Managers. In 41 District Health Authorities it appeared from the published information that there was no NHS provision of services for people with learning disabilities, but it could not be guaranteed that this was the case. Consequently an additional covering letter was sent asking District General Managers in those authorities to either forward the questionnaire to the appropriate service manager for completion or to return a tear-off slip to the effect that their Authority does not provide nor plan to provide services for this client group. Overall, 73% of the population to whom this questionnaire was sent were DMUs or DHAs, and 27% were NHS Trusts.

4.1.2 Validity and Reliability The issue of validity was addressed as part of the feasibility study carried out in Phase 2. The specific issues which the questionnaires addressed emerged from the responses from Regional Health Authorities and from the group discussion and interviews held with middle managers of services for people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness. As most of the questions were open-ended, seeking views and opinions, the survey should be seen as exploratory rather than definitive.

To test the reliability of the survey instruments the questionnaires were piloted with members of the project Steering Committee who were eminent members of the mental handicap nursing profession.

The questionnaires are appended to this report, in Appendix A.

4.1.3 Responses The Colleges of Nursing and Midwifery/ Health Studies were asked to return the questionnaires a month after they were sent out. Most of those who responded did so within that timescale, although a few were returned later. In the event, a total of 70 questionnaires were returned, a response rate of 54%. Although this response rate is disappointing, it is the response from the total population of Colleges rather than from a sample of Colleges. Whilst Oppenheim suggests that this would be not be a very satisfactory response rate, he equally describes 80% as 'poor'. (Oppenheim, 1966, p. 34) The real problem is that of bias introduced by the unknown characteristics of respondents as compared to non-respondents. However, it should be remembered that the information sought by the questionnaire was primarily qualitative and not intended to provide quantifiable and therefore generalisable data. Equally, for similar reasons, the study was intended to be exploratory rather than definitive. The fact that this research was carried out at a time when the extent and pace of change within the NHS and its providers of training in part may explain this response rate. A number of those who did respond referred to College re-structuring as a reason for the lengthy timescale before new courses could be introduced. It is not perhaps unreasonable to suggest that major organisational changes might deter people from responding to such a survey.

The 183 purchasers of training were also asked to respond within a month of receiving the questionnaire. By that date responses or acknowledgements had been received from 29 DMUs and from 10 NHS Trusts. This had increased to 55 from DMUs (including 7 returned via District General Managers) and 12 from Trusts by the time of analysis, making a total of 67, a response rate of 37%. Although the numbers are small, the distribution of respondents by organisational structure suggests that DMUs were more likely to have returned the questionnaire. This is the only characteristic in respect of which respondents can be compared with the population as a whole. It is perhaps also worth mentioning that two potential respondents contacted the research team eight weeks after the questionnaire was sent out - it had only just filtered through the organisation to reach the correct person to complete it, and these managers were asking if it was too late. In both cases they were informed that a response in the very near future would be useful, but if this was not possible there would be no point in completing it. This anecdotal evidence suggests that the strategy of trying to target the manager nearest the point of service delivery was sensible, although time-consuming.

Given this low level of responses the information collected from this source is provided as indicative of the sorts of issues identified as a result of the survey rather than as generalisable findings.

The wealth and richness of data provided by those who did respond to both questionnaires was impressive and is reported in Chapters 5 and 6.

4.2 **Semi-structured interviews**

In addition to the questionnaires four interviews were held with training providers, as follows:

a) College of Health course tutor in respect of the jointly validated course (ENB 705 and CCETSW PQS/79), 'Behavioural Approaches for Professionals working with People who have Learning Disabilities';

b) College of Health course tutors in respect of the ENB NO2 and CCETSW PQS/87 course 'Understanding and Working with Challenging Behaviour' & the ENB 939 'Care of People with a Mental Handicap in Community, Residential and Day Care Services;

c) Course tutors (Workers' Educational Association/Council for National Academic Awards accredited course entitled 'Developing Skills and Strategies in relation to Challenging Behaviour');

d) Principal, an independent residential school for children with 'severe and complex' learning disabilities and severely challenging behaviour.

These courses were selected for more in-depth enquiry for various reasons. The first two courses were selected because they were jointly validated and had a national profile. The other courses were identified from the Phase 1 research - both therefore had a high public profile. The WEA course was of particular interest in that the course syllabus included work on mental illness, and the School because it was developing training to meet the specific needs of its own staff (although the training was also made available to other agencies), and had a very explicit commitment to the value of training and quality in the provision of training. Both these courses were open to students with any professional qualifications or none. In addition, both had adopted different ways of approaching the validation and accreditation of training. None of these training providers were selected as being representative of providers in this field in general. Rather, they were identified as committed to inter-disciplinary training and as having a national profile in relation to training staff who work with people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness.

The questionnaire to training providers was used as a guide to focus these interviews, but the issues were discussed in some depth and related material emerged during the interviews. The time taken varied from 1.5 hours to half a day where it was combined with a visit to the school.

Data from both interviews and the open-ended questions in the survey were analysed by means of content analysis. Details of the training provided by all these providers are to be found in the Directory (Section III) and an account of the interview data and survey material is provided in Chapters 5 and 6.

Summary

In this chapter the methods adopted in this research have been described, along with the development of the project through the three phases. The limitations of the data have been identified.

In the following chapters the results from the literature review are reported.

CHAPTER 2

THE POLICY BACKGROUND

Introduction

In 1989 the Department of Health published Needs and Responses (DH, 1989a) in which a specific group of people with learning disabilities were seen as presenting particular problems for policy makers and for service managers. These clients were defined as people 'with mental handicap who are mentally ill, who have behaviour problems or who offend'. The nature of these difficulties included not only the most appropriate model of service provision but also the nature of staff skills and the provision of training for staff working with them. In addition to issues around the provision of training for staff working with this client group and the most appropriate model of service, changes in the structure of provision - of both services and training have been introduced. The 'contract culture' with its distinction between purchaser and provider has been brought to bear in relation to both. This has taken place as the introduction of the distinction between health and social care has generated further discussion about the most appropriate skills and professional training for staff working with people with learning disabilities more generally.

In this chapter a brief overview of these developments will be given, as the backcloth to the work carried out for this project.

1 The contract culture

Significant developments accompanied the changes introduced into the NHS. In terms of organisational structures and administrative responsibilities the implementation of the NHS and Community Care Act, 1990, saw the introduction of the internal market and distinctions being made between purchasers and providers. In terms of service provision the establishment of purchasers or commissioning authorities was accompanied by the separation of directly managed units and, at an increasing pace, the establishment of separately managed NHS Trusts.

In relation to staff training, this Act set the framework and rationale for the first contracts based upon the direction for nurse education and training contained within Working Paper 10 (DH, 1989b). The responsibility for the purchase of pre-registration professional education now lies with the Regional Health Authorities and for the provision of that training with Colleges of Nursing and Midwifery/Health Studies, often in conjunction with departments of health studies in institutions of higher education.

2 Meeting Individual Need and Shared Training

One of the primary objectives of Government policy (DH, 1989c) is to make services more sensitive to the needs of individual users. The philosophy of a 'needs-led' service pervades the entire White Paper, and the following quotations give a flavour of what this might mean in practice. As far as social care is concerned, the responsibilities of local authority social services will include (para. 3.1.3):

"* carrying out an appropriate assessment of an individual's need for social care .... before deciding what services should be provided;

* designing packages of services tailored to meet the assessed needs of individuals and their carers."

The policy goes on to affirm that:

> "The aim should be to ensure that all available

> resources are put to best use, consumer choice and involvement are enhanced, and flexible services are provided which are tailored to individual need". (para 3.1.4. emphasis added)

This theme was further taken up in relation to training by the Department of Health and Social Services Inspectorate in their report on Training for Community Care: A Joint Approach. In this document the training implications of this emphasis on a needs-led service are made very clear. (DH/SSI, 1991) In arguing a case for the contribution of shared training they state that shared training is fundamental to achieving the aims of Caring for People because (para 1.12):

> "* the focus of services needs to shift from being agency (supply) driven to one which is user and carer centred. Agencies will therefore need to integrate their approach and shared training is a vehicle for this.
>
> * 'Caring for People' requires priority given to users with the greatest needs. This will mean in practice that users with complex health and social care needs will have to have these met, in a coordinated way, by a variety of agencies.
>
> * Common training needs of staff in different *sectors* can often be met most economically by shared training activities".

More recently, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) issued a policy statement (Registrar's Letter, 1992) stressing the importance of shared learning. The UKCC prefers this term to avoid the 'potentially misleading' terms of joint or shared training. The values of shared learning are listed as improving:-

collaboration and cooperation in care;

understanding between members of the care team;
cost-effectiveness.

3 Services for people with learning disabilities - and who exhibit challenging behaviour

In 1971 the Government published the White Paper Better Services for the Mentally Handicapped which was to provide the direction for policy for those with a mental handicap for the next two decades. There was to be an approximately 50% reduction in hospital beds with a corresponding increase in community facilities and services (DHSS, 1971).

Commentators queried a number of aspects of the White Paper including the assertion that there would always be some who required 'treatment' in a hospital environment (Brown, 1991). Although the terminology changed in subsequent years - with those the White Paper saw as requiring 'treatment' increasingly being referred to as presenting 'challenging behaviour' - the general thrust to 'an ordinary life' for those with a mental handicap tended to obscure, as a matter of principle, the differences between those with a mental handicap. This did little to clarify the elements of service provision for those with 'challenging behaviour'.

While the DHSS published a small number of circulars on challenging behaviour, the most recent in 1989 (DH, 1989), it was still the one group that both District Health Authorities and Social Services Departments felt greatest confusion over when it came to planning an appropriate caring environment (Brown & Shaw, 1987). With publication in 1989 of the White Paper on community care, Caring for People (DH, 1989c), and the distinction between health care and social care being used as the basis for allocating lead responsibility between agencies, the need for clarification over the services required for those with challenging behaviour came to the fore. At the same time, the training of nursing staff who work with those with a challenging behaviour has taken on a new prominence.

4 Staffing and staff training

The long-standing debate over the role of the mental handicap nurse took on a different complexion throughout the 1980s. The increasing moves to joint training with social work from the mid-1980s onwards (Walton & Brown, 1989, Chapter 5), and the introduction of a new RNMH Syllabus in 1982 (The General Nursing Council for England and Wales 1982), highlighted evolving roles and responsibilities for staff working in mental handicap.

In nurse education, the formation of colleges of nursing and midwifery/health studies has been completed across the country, new links have been made and old alliances consolidated with higher education. Over the period in which this research was carried out, a number of Colleges of Nursing and Midwfery/Health Studies have merged - either with each other or with departments in institutions of higher education. Project 2000 programmes have been validated in increasing numbers while the UKCC has taken further its Post Registration Education and Practice (PREP) proposals (UKCC, 1990) and the Board developed its initiative on the Higher Award (ENB, 1990).

In the field of learning disabilities the publication in 1991 of the Cullen Report (CNOs, 1991) on the future role of the mental handicap nurse embraced the distinction made in Caring for People, between health and social care. In a manner that was low key compared to the publicity that attended publication in 1979 of a similar exercise, the Jay Report (DHSS, 1979), Cullen emphasised the relevance of mental handicap nursing skills across the health and social care continuum. In particular, however, a case was put forward that a distinctive contribution was to be made in health care with the emphasis in the report being placed upon challenging behaviour - an argument that served to reinforce the potential importance of work being carried out for the present project.

These actual changes were accompanied by many other proposals for change. Not least, proposals made early in 1991 by the Government on the relationship between the National Boards and the UKCC were confirmed before the end of the year.

Conclusion

The work of this project has been carried out in a climate of major change. In the next chapter the issues of defining challenging behaviour and identifying mental illness in people with learning disabilities are reported.

CHAPTER 3

ISSUES OF DEFINITION

Introduction

In this chapter the issues of terminology are considered, followed by discussion of the diagnosis of mental illness in people with learning disabilities.

1 Challenging Behaviour

There is no absolute definition of challenging behaviour. The term has evolved from a series of discarded labels - aberrant, problem, difficult - referring to the presence of socially unacceptable behaviours. The term covers a wide range of behaviours from inappropriate verbal habits to violence. Part II of the Adaptive Behaviour Scale identifies the following (Nihira, et. al, 1974):

violent behaviours
anti-social behaviours
rebellious behaviours
untrustworthy behaviours
stereotyped behaviours
inappropriate interpersonal behaviours
unacceptable or eccentric habits
self-injurious behaviours
hyperactivity
sexually-aberrant behaviours
psychological disturbances.

The use of the term challenging behaviour to refer to a host of behaviours differing widely in causation, manifestation and severity arises from convenience. The main and sometimes only common element shared by behaviours termed 'challenging' is the problem they pose for service delivery. (BIMH, 1991, p.1)

In terms of policy development, challenging behaviour has been identified as one of a group of possible additional needs experienced by people with learning disabilities. The government publication Needs and Responses: Services for Adults with mental handicap who are mentally ill, who have behaviour problems or who offend (DH, 1989a) was produced by a study team given the task of looking at problems posed by autistic people, people with mental handicap with an overlay of mental illness and by people with a mild mental handicap who are delinquent. This report first introduced these three distinct areas of additional need. These have subsequently been adopted for discussions on policy.

A further distinction in the definition of client groups has been evident in recent publications, Challenges and Responses (DH 1991) and Service Responses (BIMH 1991) both of which have tended to focus attention on individuals with profound learning disabilities. The reasons for this can be explained thus;

a) first, the prevailing ethos of normalisation holds that every individual, regardless of level or severity of disability, has a right to live in the community;

and

b) there is wide acceptance that incidence and severity of challenging behaviour rise significantly with the level of disability, a factor which can often impede the former.

Obviously therefore it is a matter of priority that those exhibiting extremely challenging behaviour receive adequate support once in the community. The most frequently quoted reason for the failure of a placement in the community, is aggressive and violent behaviour resulting in the return of the individual to hospital provision. (Lander-man Dwyer, et. al, 1981)

Hence implicit in the focus of the government's most recent publication (DH, 1989a), there is an informal distinction between levels of challenging behaviour. However it would not appear that this distinction is commonly understood by those working 'hands-on'. Front-line care staff use the term challenging behaviour indiscriminately when referring to behavioural disorders across the spectrum. The confusion surrounding the use of the term 'challenging behaviour' in the nursing community was highlighted in correspondence (Letter, 1989), and confirmed more recently as follows:

> "not only do different categories of challenging behaviours have different causes, forms and function, ... but also ... the same behaviour in different people may have different causes or functions and be appropriate or inappropriate depending on the person." (Darbyshire & Whittaker, 1990)

Any discussion of definitions needs to acknowledge the problems created by differential usage of definitions between those working in the field and those responsible for planning services. The precise understanding or application of the phrase to particular individuals also has implications for training needs analysis and training provision.

To compound this situation it has been recognised that different health and social service departments 'may adopt different definitions as a basis for deciding who is or is not regarded as presenting challenging behaviour' (Bridgen and Todd, 1990). This necessarily results in differing patterns of service developing across the country, with correspondingly different implications for training.

This situation is compounded by contentions between theoretical models for the assessment and management of challenging behaviour, the implications of which are discussed in the following section.

Despite the variety of behaviours subsumed by the term 'challenging behaviour' a number of definitions have gained acceptance in official publications. The criteria adopted by the Department of Health for determining what constitutes challenging behaviour derives from Zarkowska and Clements' (1988) definition. This states that a behaviour may be regarded as a problem if it satisfies some or all of the following;

> "The behaviour itself or its severity is inappropriate given a person's age and level of development.
>
> The behaviour is dangerous either to the person himself or to others.
>
> The behaviour constitutes a significant additional handicap for the person by interfering with the learning of new skills or by excluding the person from important learning opportunities.
>
> The behaviour causes significant stress to the lives of those who live and work with the person, and impairs the quality of their lives to an unreasonable degree.
>
> The behaviour is contrary to social norms" (Zarkowski and Clements, 1988).

This provides clear guidelines in the form of five characteristics. Alternatively definitions exist which are less specific and reflect an emphasis on the philosophy of care appropriate to dealing with challenging behaviour. Thus a frequently quoted definition from the King's Fund Centre goes as follows;

> "The term challenging behaviour is used to emphasise the fact that the issue is a challenge to those who provide services, and to the rest of society, not just a problem carried around by the individual. The challenge is ours to find effective ways of helping people to behave and express themselves in ways which are acceptable to society." (Blunden and Allen, 1987)

Definitions invariably reflect the context within which they were devised. Initiatives by the South East Thames Regional Health Authority to provide support services for mentally handicapped people with special needs in the community, took the form of a Special Development Team. In conjunction with the University of Kent, this peripatetic team undertook a supportive role to local services by developing and supporting individualised community-based services for people with severely challenging behaviour.

The definition they devised in the early stages of their work combines a practical working tool and something of a philosophy:

> "Severely challenging behaviour refers to behaviour of such intensity, frequency and duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities" (Emerson et al., 1987).

This definition incorporates the principles of normalisation and community care. As such it has become one of the most widely quoted definitions representing a workable formula around which services can be planned.

This overview of the issues around the use and meaning of the term 'challenging behaviour' indicates that the use of the term challenging behaviour covers a range of widely differing behaviours. Definitions have evolved largely as a response to the needs of service planning to place people in categories. Differing interpretations of the term challenging behaviour between those who work 'hands-on' and those responsible for planning services is an additional area of confusion. The understanding of mental illness in people with learning disabilities is similarly not straightforward, and the next part of the chapter will consider this question.

2 Mental Illness and challenging behaviour

The following material includes a discussion of terminology in the field of mental health/illness, prevalence of mental illness in people with learning disabilities and the recognition of mental illness in this client group.

2.1 Terminology

Before embarking on a discussion of mental illness in relation to people with learning disabilities, some consideration must be given to terminology. The field of mental health is in itself fraught with difficulties in this respect; to the lay person, classification of associated conditions in mental health can only add complexity to the issue of mental illness amongst populations with a learning disability. Briefly therefore, the relevant terminology can be explained as follows.

The classification of mental disorder is inconsistent as it is informed by two institutions, the International Classification of Diseases (ICD-9) (World Health Organisation, 1977) and the Mental Health Act for England and Wales, 1983.

The first of these includes under the category of mental disorders:

psychoses and neuroses
personality disorders,
mental retardation,
sexual deviancy,
and
chemical dependency.

In a similar vein, although not as broadly, the Mental Health Act 1983 (MHA) specifies four categories under which a person may be compulsorily detained for assessment and treatment. These are:

mental illness,
mental impairment,
severe mental impairment (arrested or incomplete intellectual development), and
psychopathic disorder.

Mental disorders are therefore understood to comprise any disorder or disability of the mind. Changing the prefix to psychiatric does not alter this meaning. Mental illness in this context is taken to be one of a range of disorders. The Dictionary of Mental Handicap quotes mental illness as being synonymous with psychiatric illness. Confusingly, the same source also suggests that the term psychiatric illness is interchangeable with psychiatric disorder. (Lindsey, 1989) However this is questionable. Mental illness is clearly listed as one of a range of possible categories of mental disorder under the MHA. There is no suggestion of a reciprocal relationship; otherwise, learning disability could be classified as a mental illness, which clearly it is not.

In the absence of any firm conventions governing the use of terminology in this field, wherever possible the term **mental disorder** will be used in reference to the whole range of psychiatric impairments including learning disability, mental illness, and associated behaviour disorders. **Mental illness** will refer to a more specific range of psychiatric disturbances.

It is worthy of note at this point, that under the terms of the MHA, individuals being sectioned under the categories of 'mental impairment' must additionally exhibit 'seriously irresponsible or abnormally aggressive behaviour'.

It has been argued (Holland and Murphy, 1990) that this behavioural element is poorly defined, omitting as it does to indicate 'the type, severity or frequency of such behaviour'. Although such a behaviour disorder may be the result of a mental illness, it is likely that detention of people with a learning disability will be made under a category of 'mental impairment'. This effectively means that behaviour disorders can be classed as mental disorders, regardless of the function of the behaviour.

For the purposes of this report, the terms **'behaviour disorder'** and **'challenging behaviour'** will be used interchangeably, to mean:

> "Behaviours which seriously interfere with the normal life of a person or the lives of those with whom he or she comes into contact." (Lindsey, 1989)

Additionally, **'extremely challenging behaviour'** will take its definition from the Special Development Team, at the University of Kent (Emerson et al., 1987):

> "...behaviour of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities."

Challenging behaviour will not normally be understood to mean a mental disorder, except where an author states so explicitly.

One final note should refer to the further variations presented by American authors. 'Mental retardation' refers to learning disability; mental disorders and mental illness are sometimes vaguely referred to as 'psychiatric impairments' or 'psychiatric factors'. 'Dual diagnosis' is the term given to the simultaneous presence (and recognition) of a mental illness and a learning disability.

2.2 Prevalence rates of Mental Disorders amongst People with Learning Disabilities

Holland and Murphy (1990) have reviewed the figures available for the prevalence of mental disorder, including psychiatric illness, autism, hyperkinetic syndromes, organic brain disorders, disorders of personality, disorders of behaviour and neurotic disorders in people with a mild learning disability.

Studies have reported rates of mental disorder as high as 25% (Ballinger and Reid, 1977) to 50% (Lund, 1985), where approximately 10% were behaviour disorders. However, methodological difficulties associated with ascertaining accurate numbers of people with a mild learning disability in a given population, or applying strict criteria for psychiatric illness on people with severe learning disabilities, limit the reliability of such figures. However, despite these weaknesses there is significant evidence, corroborated by studies in the United States of America (Jacobson, 1982; Menolascino and Stark, 1984) that rates of mental illness are higher amongst people with a learning disability than for the rest of the population.

Reasons for this are relatively unknown as there is a lack of research into this area. Theories have been suggested that there may be a correlation between underlying abnormalities of brain structure and function or the effects of the increased prevalence of epilepsy (Holland and Murphy, 1990). Amongst people with mild learning disabilities, mental illness might be due to social and psychological factors, such as being aware of differences between self and the rest of society, or social attitudes towards disability which lead to isolation and segregation (Russell, 1991).

Lack of knowledge in this area has prompted calls for the recognition of new specialisms in the Psychiatry of Mental Handicap,(Day, 1991) to encourage further research. The call for specialist provision however, contradicts the prevailing ethos of an 'ordinary life' and access to generic services for people with learning disabilities who have additional needs. It is also aimed at a culture which is largely unfamiliar with the concept of mental illness and learning disability presenting simultaneously.

2.3 Recognition of Mental Illness in People with a Learning Disability

There is another issue which needs to be taken into consideration when defining challenging behaviour. A particularly problematic aspect of using the term challenging behaviour is that it masks a significant area of overlap with psychiatric illness.

The 'dual diagnosis' movement in the US has been responsible for promoting recognition of the prevalence of mental illness amongst people with a learning disability. There is much more widespread recognition of the association between mental illness and behavioural problems (Hodgins and Monfils, 1985). In the UK, interest has tended to focus primarily on the behaviours which impede successful community integration, rather than on the needs of people with learning disabilities who additionally suffer from a mental illness .

In his article on 'dual diagnosis in the US', Reiss (1988) notes how the pioneering work of Menolascino, amongst others:

> "has served to increase recognition of the existence of dual diagnosis, and the fact that people with a learning disability are vulnerable to the full range of mental health disorders." (p. 43)

The article further notes that:

> "a major purpose of the dual diagnosis movement is *to correct the imbalance* [of concentrating on the treatment of behaviour problems] by *increasing services and research on the full range of mental health disorders seen in people with mental retardation.*" (ibid., emphasis added)

The historic concentration on the treatment of behaviour disorders, is now believed to be inappropriate in the light of evidence which suggests that:

> "for every mentally retarded person in the United States who needs treatment for a severe behaviour disorder, there are ten who need training in social skills, and *two who need treatment for depression*" (Reiss, 1988).

In the UK, 'dual diagnosis' is a term which is only now beginning to gain recognition. In Meeting the Challenge (Allen et al. 1991) the difficulties in identifying the responsibility for providing services for people with learning disabilities and mental illness are attributed to the fact that their needs cross the traditional lines of professional responsibility.

Like the period between 1960 to 1985 in the US, attention in the UK has focussed on the assessment and treatment of challenging behaviour in itself, to the detriment of wider considerations of mental health.

The poor recognition of the mental health needs of people with a learning disability in the UK has been attributed to professional resistances (Cox, 1992). The similarity (until the recent adoption of the term learning disability) between the terms mental handicap and mental illness, has been responsible for a great deal of public misconception which associated professions have been at pains to correct. Subsequently it is suggested that there is now an in-built resistance to any association between learning disability and mental illness.

This theory is further corroborated by the conflicts which emerge when theoretical models used in psychiatry and learning disability are compared.

Professional tensions are created when staff and clinicians try to assimilate a medical model of mental illness into models of behavioural disturbance and learning disabilities. Over the past twenty years there has been a marked shift from the traditional approach, rooted in the medical model of learning disability to a psycho-educational one. Behavioural psychology replaced passive philosophies of **caring**, with more active interventions, aimed at **teaching**. Further detail of these changes can be found in Cameron et al, 1984.

The effects of this have been profound, shaping current ideology in the field of learning disability which holds that every individual has a capacity to learn whatever their level of disability. The issue at present is which method of teaching is appropriate for the adaptation of challenging behaviours, given that behaviour modification is now only one of a range of suitable interventions (Brandon, 1990 and Murphy, 1991).

The rejection of the medical model of learning disability was therefore complete. However, there remain arguments put forward by the school of psychiatry that this model is appropriate given the complexity of diagnosing a mental disorder. It has been suggested that the traditional medical model provides a useful tool for ruling out psychiatric factors in behavioural evaluations (Sovner, 1984).

These professional conflicts appear to be impeding the recognition of the needs of the 'dually diagnosed', and must similarly present obstacles to the success of multi-disciplinary teams which deal with challenging behaviour. The area of overlap between mental and behaviour disorders seems to be given little consideration, with obvious implications for issues of intervention.

Summary and Conclusion

This chapter has considered the various definitions of 'challenging behaviour' and the question of mental illness in people with learning disabilities.

It would appear that amidst all the enthusiasm for normalisation and community care, there should be some time given to the clarification of what levels or types of behaviour are most commonly meant by the term challenging behaviour. Although it is clear that labelling is contradictory to the principle of normalisation, it is inevitable that some terminology will be used for a client group who exhibit behaviours which impede their integration into the community. There is a danger, as with all labels, of stigmatisation. However, it is suggested that the current confusion surrounding the term can only lead to misconceptions both public and professional ultimately hampering adequate service provision.

Furthermore, the evidence cited in the chapter suggests that service and therapeutic approaches to the needs of people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness should take the following into account:

a) terminology in the field of mental health is problematic and does not lend itself easily to the field of learning disability.

b) there is a higher prevalence of mental illness amongst people with a learning disability than in the general population.

c) despite this, recognition and comprehension of mental illness amongst the learning disabled population in the UK is poor.

d) as a result those whose needs include learning disability and mental illness and challenging behaviour are at risk of being ignored in the provision of services for both.

This literature has illustrated the complex nature of inter-relationships between mental illness and challenging behaviour and the probable under-diagnosis of mental illness in people with learning disabilities. The following terminology has been adopted in the rest of this report. The client group will be described as:

> People with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness.

Although somewhat wordy, this description allows that each element of people's needs are distinct and recognises that more people might be diagnosed as having a mental illness if 'dual diagnosis' were more current in this country.

The next chapter draws together material on therapeutic approaches to, and models of service provision for, this client group.

CHAPTER 4

THERAPEUTIC RESPONSES AND SERVICE MODELS

Introduction

In the last chapter evidence was produced to suggest that there are two basic issues facing those who wish to develop services and meet the training needs of staff working with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness. These are:

a) The various, and very general, definitions of challenging behaviour may well have their consequences for determining the type of service provided for this client group.

b) Professional conflicts appear to be impeding the recognition of the needs of the 'dually diagnosed', and similarly may present obstacles to the success of multi-disciplinary teams which deal with challenging behaviour. The area of overlap between mental illness and behaviour disorders is given little consideration, with obvious implications for issues of intervention.

There are two further issues, however. The first has already been indicated (Chapter 3, p.34). This concerns the variety of therapeutic approaches to meeting the needs of people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness. The particular approach(es) adopted in any service may influence the type of service provided and will certainly influence the training needs of staff working with this client group. The second is the range and type of models of service which are adopted and promoted for meeting their needs. A brief account of the main therapeutic approaches will be provided next.

1 Therapeutic responses to challenging behaviour

With the move away from the medical model of meeting the needs of people with learning disabilities the primary therapeutic response to behavioural difficulties would seem to have been that of behaviour modification. The main techniques identified from the literature include:

a) traditional behavioural techniques (behaviour modification)
b) cognitive-behavioural approaches
c) positive programming
d) functional analysis
e) gentle teaching
f) physical management

A brief note on each of these will be provided next.

1.1 Behaviour modification

This is the traditional approach applied to people with learning disabilities (Murphy, 1991, p. 51) and includes stimulus control, negative and positive reinforcement and time out. This approach is founded on the assertion that 'behaviour is a function of its consequences' (Bailey & Pyles, 1989). It has been described as the 'most important technique for teaching self-help skills, socially acceptable and independence behaviours' (Sacks, 1987, p. 48). This author further asserts that it is:

> "Often the only effective treatment for self-help skills, social skills and independence behaviours as well as for the reduction or elimination of undesirable behaviours" (ibid.).

Although behaviour modification does not solely rely on aversive or punishment oriented techniques it is these that have 'special problems' and 'can be misused' (Sacks, 1987, p.49). The additional difficulty with the traditional emphasis on the consequences of behaviour has been that some practitioners may have ignored other possible causative factors. Alternative causes might include 'a variety of physical, environmental and medical circumstances' (Bailey and Pyles, 1989 p. 86). To concentrate on manipulating the consequences of behaviour when it is the antecedents to which the behaviour is a response is likely to be not only ineffective but also unethical. Examples might include applying behaviour modification techniques to reduce head-banging which is in fact caused by the side-effects of a psychotropic drug.

1.2 **Cognitive-behavioural techniques**

These techniques, it is argued, (Murphy, 1991, p. 51) have been more usually employed with people who do not have learning disabilities. However, there is a growing interest in the application of these techniques in the area of learning disabilities and challenging behaviour. Cognitive-behavioural approaches include:

relaxation training
desensitisation
anger management
social skills training
sex education.

Some of these techniques can be used to enable clients to control behaviour

1.3 **Positive Programming**

This approach has been developed and promoted by LaVignia et al. (1989). The particular emphasis is on a move away from aversive or punishment-based approaches, except in very specific circumstances. It is particularly applied in relation to severe challenging behaviour in the presence of severe learning disabilities. It is defined by the authors as a:

> "longitudinal, instructional programme designed to give the learner greater skills and competencies for the purpose of controlling or eliminating problem

> behaviour in order to facilitate and enhance social integration". (LaVignia, 1989, pp. 59-60.)

The authors distinguish between proactive and reactive responses to behaviour. Reactive strategies include stimulus change and crisis intervention as well as active listening (intervening to remove the need for the behaviour). The dangers of reactive responses are that they may either reinforce the behaviour or may 'contain an unavoidable aversive quality' (p. 61). These strategies have the advantage of more rapid and immediate responses to behavioural problems.

Proactive strategies on the other hand take longer to take effect but are more likely to be generalised and more permanent. These techniques include environmental manipulation (planned changes in the environment which lead to changes in behaviour) and direct treatment approaches. The latter may be either behavioural or non-behavioural. The former include differential reinforcement of behaviour, stimulus control and other operant conditioning approaches. Non-behavioural direct treatment might include changes to diet or adjustment to medication. Finally, according to this model, there is positive programming. This approach includes the following variations:

a) teaching general skills - in the areas of domestic, vocational and community functioning;

b) teaching specific skills - to enable the client to achieve the desired results without resorting to 'challenging behaviour'. The teaching of acceptable means of communication as opposed to hitting or tantrums to express boredom or loneliness are given as examples;

c) teaching specific skills - to enable the client to develop alternative responses to unwanted constraints or situations - such as learning to make choices or, in respect of undesirable but not dangerous behaviour, only to engage in that behaviour under certain, limited circumstances.

d) teaching coping and tolerance - which include relaxation training or desensitization to the stimuli which seem to trigger challenging behaviour.

Positive programming depends on a very thorough and detailed assessment and analysis of the problem behaviour. It is particularly important to identify the communicative functions of the behaviour perceived as challenging.

1.4 **Functional Analysis**

Functional analysis, also called behavioural diagnostics (Bailey & Pyles, 1989) is, as the terminology suggests, concerned with the analysis of the reasons for behaviour - particularly in relation to communications. It is argued that the first step in working to prevent challenging behaviour over the long term is to identify the purpose or function it serves for the individual concerned. The questions to be asked in respect of such behaviour include:

a) in what circumstances does the behaviour occur, and, more importantly, not occur?

b) are there any physiological factors which might be implicated (eg pain, discomfort, side-effect of medication, allergies)?

c) are there any operant variables - specifically any stimuli/responses which reinforce or trigger the behaviour?

d) are there any serious consequences of the behaviour? - if not, it may be best left untreated.

1.5 **Gentle Teaching**

Brandon (1991) gives an account of this non-aversive approach to challenging behaviour which originated in Canada. The emphasis is on teaching rather than controlling, on mutual respect and equality in relationships rather than on domination. There are few 'techniques' as such, rather:

> "it is essential to teach the person [whose behaviour challenges] by experience that there is value and goodness in human relationships... A central component of gentle teaching is re-direction. This means teaching responses that focus on rewarding...." (p. 63)

Brandon further explains that:

> "techniques can be dangerous and general prescriptions are of limited help. In gentle teaching the self is offered gently. Gentleness is a process of melting rather than breaking down defences. It requires tolerance, warmth and affection in eliciting behaviour which is reciprocal and humanising" (ibid).

In gentle teaching, therefore, the emphasis is on values, common humanity, relationships and the 'spontaneous giving of self' in those relationships.

1.6 **Physical Management of Behaviour**

In times of crisis when there is a real risk of injury to either self or others it may be necessary to respond to challenging behaviour by means of physical control. The most extensively used approach in this country is probably the 'Control and Restraint' techniques taught by Home Office approved trainers. This technique involves holding people in such a way that, if they resist, their own movements cause sufficient discomfort to cause them to cease the struggle. An alternative approach, which has been introduced from the US comes from Strategies for Crisis Intervention and Prevention, provided and marketed by the New York State Office of Mental Retardation and Developmental Disabilities. In the physical control element of this overall approach, the emphasis is on 'soft touch' where there is no use at all of discomfort on the part of the person being restrained.

Other physical responses include break-away techniques where staff are trained in ways of breaking the hold of others.

Techniques for de-escalating aggression before it becomes actual violence are the preferred option - such as active listening, anger management and relaxation.

1.7 **Overview**

This brief report of some of the techniques available for working with people with learning disabilities and challenging behaviour illustrates the wide range of theoretical and practical responses to behavioural difficulties, and indicates that there may be some tension between the proponents of different models. The next part of this chapter will consider some of the issues around service provision for this client group, and the various models which have been developed.

2 Issues in provision

2.1 Services for people with learning disabilities and mental illness

Currently normalisation principles are dictating the integration of this client group into mainstream psychiatric services. Evidence from Denmark, however, highlights some of the problems with this policy.

Following large-scale community integration programmes, staff in mainstream psychiatric services felt unable to cope with the demands made by this client group, complaining that they did not have the training or the resources to provide for this influx. Subsequently the number of people with a learning disability admitted to mental illness hospitals had doubled (Corbett, 1991).

This type of evidence lends strength to the arguments being put forward in favour of developing special psychiatric provision for people with learning disabilities. One consultant psychiatrist believes that the policy of community care and the closure of large mental handicap hospitals has failed to meet the needs of people with learning disabilities (especially the profoundly disabled, with an IQ of 75 or less) who exhibit mental illness or behaviour disorders (Day, 1991, p. 19).

Dr Day believes that generic psychiatric services are inappropriate because the diagnosis and understanding of the presentation of a psychiatric and/or behaviour disorder in a person with a learning disability requires specialist skills. Others from the school of psychiatry agree that whilst it is important to be aware of the possibility of psychiatric factors producing a challenging behaviour, they also believe that this can be achieved within the principles of normalisation. Others (Russell, 1991 and Corbett, 1991) believe that the optimum service provision will come from marrying the relevant expertise of mental health professionals with the skills of professionals already working with people with learning disabilities.

What both models of provision have in common, is recognition that there is currently a gap in provision for people with a learning disability who in addition suffer from a mental illness, whether this presents itself as a challenging behaviour or not.

The special initiatives in the UK, which explicitly recognise the overlap between mental illness and challenging behaviour (such as the Mental Impairment Evaluation and Treatment Service (MIETS)) tend to concentrate on individuals with mild learning disabilities. Those individuals with profound disabilities who either lack or have poorly developed communication skills present greater challenges, both in terms of accurate diagnosis and in terms of the behaviour presented. It therefore has to be recognised that different skills will be required of staff working with this client group, depending on the level of the individual's communication skills, and the nature of the challenging behaviour.

2.2 **Services for Challenging Behaviour**

How additional services for clients with profound disabilities and/or extreme challenging behaviour, should be provided is currently being debated.

With regard to service provision for people with extremely challenging behaviours, there are essentially two models of care. The first suggests the creation of specialised treatment units provided by Health Authorities. The second solution is for Health and Social Services departments to jointly provide support for individuals in the community, either in the family home or in residential group homes.

The former is said to have the advantages of providing the best environment for assessment and treatment by a range of skilled professionals. The risks of isolation from the community and continued institutionalisation are avoided in the second model, although there is a fear that the expense of small scale community provision may lead to well-intentioned but low-quality unskilled care. (Kiernan, 1987, and Newman and Emerson, 1991, provide an overview of these issues.)

The King's Fund Centre has reviewed initiatives attempting to meet the needs of people with challenging behaviour in the community based on the principles of an "ordinary life" (Blunden and Allen, 1987). None of the services reviewed are set out as a blue-print; they are merely presented as proof that such provision is feasible and not prohibitively expensive.

The initiatives reviewed are all geared towards the provision of "community-based services based on individual needs". The range of services include residentially based services, peripatetic community support teams, occupational and employment schemes (Allen et al. 1991). Each has its merits and drawbacks, but nearly all are hampered by lack of security in future funding. They argue that:

> "At the time of writing, it is rumoured that an anticipated policy statement from the Department of Health will pull back from the firm commitment to community-based services based on individual needs" (p. 1)

Although this rumour has not been translated into reality there is still much anxiety about the levels of funding which are likely to become available for community care services (News, 1992).

Little consideration is given explicitly to the extent to which issues of mental illness are addressed within each of these environments. The philosophy appears to be that where challenging behaviours are demonstrably checked or reduced, the project is deemed to be a success. The overlap between behaviour disorder and mental disorder is not understood to be a significant issue where a challenging behaviour is successfully managed.

Equally, there is little consideration given to what skills are necessary for the success of each project, as these are variously governed by who is sponsoring the initiative and the philosophy of care which is accordingly adopted.

The issue of determining what the appropriate skills are for working with this client group is controversial and broad. For the purposes of this paper, only the skills necessary for diagnosing mental illness amongst people with a learning disability who exhibit challenging behaviour will be briefly outlined.

2.3 **Skills and Training**

Part of the argument which favours specialist care for extreme challenging behaviour and/or mental disorder, is the concern that this client group requires staff with specialist skills.

Most people with a learning disability will have some difficulty in communicating their needs and feelings. This difficulty will increase with the level of disability, so that people with a profound learning disability may have very limited non-verbal communication in addition to short attention spans.

Diagnosis of a mental illness usually relies on:

> "the basis of *what the patient says* and on what the physician observes" (Russell, 1991, emphasis added).

Where a person has difficulty expressing his/her thoughts and feelings, diagnosis will have to rely solely on observation. This may involve skilful interpretation of non-verbal communication and/or the ability to note subtle changes in behaviour over a period of time.

It follows therefore that diagnosing a mental disorder in a person with a learning disability requires skills and knowledge in the field of learning disability and psychiatry. Whether these skills should be present in one suitably qualified/experienced person, or whether they should be married together through inter-disciplinary teams is a subject of controversy.

One school of thought suggests that the RNMH has enough grounding in mental illness to be able to fulfil the former option, whilst another would argue that such skill derives only from 'specialist' training or units.

In the absence of national guidelines, neither the competency of existing professionals (such as the RNMH), nor the pertinence of 'specialist' skills is clear. There presently exists a range of training possibilities for staff working with challenging behaviour, which despite the lack of any explicit regulation, can roughly be divided into three types: informal workshops and short courses, in-service training programmes and more formalised training courses validated by the Board and/or

CCETSW or accredited through institutions of higher education.

As a result of the ad hoc nature in which such training has developed, these opportunities vary in availability, content and application. Consequently:

a) choice is dependent largely on the existence of local initiatives,

b) content is determined essentially by the provider,

c) the subsequent value attached to each course is subject to interpretation, in the absence of external mechanisms for determining competency (with the exception of courses validated by the Board, CCETSW and other bodies mentioned above).

These flaws originate from a lack of agreement on what constitutes appropriate approaches to challenging behaviour. Service provision for those who present extremely challenging behaviour and/or mental disorder varies across regions and districts, and it is unlikely that provision will ever be uniform whilst responsibility for determining services remains local.

It would therefore be inappropriate to impose uniform training courses across the nation; however, there presently appears to be a need for a system for overseeing the range of courses which are currently on offer.

If all training was subject to guidelines issuing from a central body, this would ensure harmonisation, by making it possible for the skills to be transferable across settings and sectors and between districts and regions. Local variation in the identification and provision of training need not be threatened, as guidelines would advise rather than prescribe course content. In this fashion, an element of mental illness might be compulsory for courses in challenging behaviour, but the scope could be tailored to the participants' prior knowledge and present requirements.

Another possible role for such a body could be to rationalise the use of terminology. Terms such as 'skill', 'competency' and 'specialist training' are inadequately defined insofar as they are used to indicate levels of proficiency, which are not clearly defined.

Conclusion

The confusion surrounding training opportunities for staff who work with clients exhibiting challenging behaviour with an overlay of mental illness, reflects the general levels of variety and difference of opinion which govern service provision for this client group. This variety applies both to the range of therapeutic responses and to the models of service provision which have been discussed.

Different approaches adopted to meet the needs of people with a learning disability who additionally exhibit challenging behaviour and/or a mental disorder have produced a disparate range of locally determined services which vary in the extent to which they address issues of mental illness.

Consideration of future staff training needs in this area should incorporate an element of flexibility in recognition of the absence of an overall rationale to the provision of such services. With the emphasis on the local development of services to meet local needs, flexibility within a framework of nationally recognised standards would seem to be the most productive way forward.

The following section of this report presents the information collected through the postal surveys from providers and purchasers of training about the issues discussed in this and the previous chapter.

SECTION II

Perceptions of Providers and Purchasers

CHAPTER 5

PURCHASER AND PROVIDER INFORMATION: DEFINITIONS, MODELS OF SERVICE PROVISION AND TRAINING

Introduction

In this and the following chapter, the information (primarily qualitative) collected from providers and purchasers of training will be reported. The methods of data collection, and their limitations were described in Chapter 1 of this report. It should be stressed that these data should be treated as exploratory and indicative in nature, given the relatively low response rates and the selection of courses to visit on the basis of the public profile rather than representativeness. Not all respondents answered all questions, so the base figure is given for each table.

Data was collected from three sources, namely questionnaires from purchasers and providers of training, and interviews with a small number of providers. In this chapter information is presented from all three sources (where applicable) in respect of the following:

a) the various definitions employed by respondents of challenging behaviour;
b) the models of service provision identified by purchasers of training, which they provided;
c) the sources and types of training which purchasers made use of for their staff working with this client group;
d) the views of both providers and purchasers on joint and shared training.

The remainder of this chapter contains a description and discussion of the responses collected, under these headings.

1 Definitions

1.1 Provider information

Table 5.1 illustrates the various responses from the providers of training given to the question seeking a definition of challenging behaviour for the purpose of providing training courses in this field.

Table 5.1: Definitions (Providers)

(N = 49)

Definition	N
Not acceptable to the community	21
Challenges providers/carers	12
Physical threat/violent	5
Disruptive/disturbed	2
Institutionalization	1
Specified Kent definition	7*
Specified Blunden definition	2*
Specified Z + C definition**	1*
Total	51

*These definitions are described in detail in the literature review, Chapter 3.

**Z & C refers to the definition proposed by Zarkowski and Clements, 1988.

There is a clear diversity of emphasis in these definitions - with some specifying particular types of behaviour (physical violence, disruption,) but the majority defining challenging behaviour in terms of its consequences - either to service providers or to 'the community'.

1.2 Purchaser Information

Table 5.2 gives the responses to the same questions, from the purchasers of training. These responses, therefore, relate to the definitions adopted in relation to identified service users.

Table 5.2: Definitions (Purchasers)
(N=63)

Definition	N
Restricts community integration/ & challenges services	13
Specified 'Kent definition'	13
Not acceptable to the community	10
Challenges providers/carers	7
Physical threat/violence	5
Disruptive/disturbed	3
Range of specific behaviours	6
No information	11
Total	67

Some respondents included more than one of the categories above. The 'Kent definition' (either specified or by a verbatim quotation) accounted for 22 of the responses and the two main elements of that definition accounted for a further 17. The remaining responses include more specific reference to physical violence (either to self or others), to disturbed or disruptive behaviour or to activities such as self-injurious behaviour or damage to property.

The substance of these definitions is not dissimilar to those provided by the providers of training, described above. From both perspectives, the specific nature of behaviour was mentioned less frequently than the consequences of that behaviour, for service providers, informal carers, the community in general, or indeed the individual him/herself, whose quality of life was adversely affected by the behaviour.

2 Models of Service Provision

Again as reported in the literature review (Chapter 4), t relative merits of a variety of models of service provision are under discussion. The type of service model adopted has implications for staff training, so the information given by respondents about the services they provide or are planning to provide is presented next. This provides the context for understanding the material about training provision, skills and standards. This material is only appropriate to the purchasers of training and was therefore only asked of them.

Of the 66 respondents, 54 were currently providing services for this client group, and 35 reported definite plans to develop such services. Thirty-two service providers reported both that they currently managed services and planned to develop new provision. Three had plans to develop services in the future but did not provide any at present; and 20 reported current services but had no plans to develop or add to their existing provision. A number of service models were reported, and a wide variety of combinations of service patterns. Table 5.3 presents the types of service and number of respondents who offered or planned each type. Information about the combinations reported is presented thereafter.

Table 5.3: Service models provided and planned

Model	Provided (N=54)	Planned (N=35)
Special support team	30	18
Residential	23	20
Assessment/treatment Unit	16	10
Day care	89	2
Community Mental Handicap Team	5	--
Respite (residential)	4	4
Psychiatry	4	1
Mental illness beds	2	2
Outreach from day care/ residential	4	2
Regional secure unit	1	--
Total	98	59

Of the service models identified, the specialist support team was the most frequently reported, followed by long to medium term residential care (either in hospital or community units), followed by assessment and treatment units. For a number of providers, the CMHT was identified as having a specialist role in this area. Respite care was mentioned, as was specialist input from psychiatrists and access to mental illness hospital beds. However, the use of psychiatric services per se did not seem to figure highly amongst those responding to this survey. Perhaps this is not surprising in view of the material from the literature review which suggests that the diagnosis of mental illness in people with learning disabilities is not highly developed in this country.

The majority of respondents reported that they offered or planned to offer more than one type of service. Only 12 actually provided only one type of service (8 special support teams, and 4 residential services), and 12 were planning to develop only one type of service (5 special support teams, and 7 residential units). However, only three respondents had only one type of service and were not planning any further developments in this field. All those who were planning future services already provided some specialist service for this client group. The most popular combination of service types (either provided or planned) was the provision of a specialist support team with some form of residential service (long to medium term, assessment and treatment and/or respite care places). Overall, a total of 23 different combinations of service model were identified, from 44 respondents.

The main point to emerge from the above data seems to be that, in relation to those service providers who responded to the survey, a number of models of service provision are being implemented at District Health Authority level with a variety of combinations of service model. This complexity and diversity of service provision provides the context in which the identification and meeting of training needs for staff working with this client group must be addressed.

Finally, on the subject of services for these clients, eight respondents reported that they were withdrawing from service provision. In all cases, some responsibility for meeting the needs of this client group was being transferred to other agencies. In two cases, responsibility was to be transferred to other agencies within the NHS; in three, local authority social services were to be the main provider; and in the remainder the independent sector was taking a role in meeting these needs.

3 Sources of training and purchaser views thereon

Respondents who currently provided or were planning to provide services for this client group were asked to identify the sources and types of training they used for their staff, their general views on the training provided and their general views on the relative merits of joint and shared training for staff working with people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness. These questions were asked in respect of qualified nursing staff, staff with other professional qualifications and unqualified staff.

3.1 **Sources of training**

Table 5.4 illustrates the range of sources from which NHS service providers were purchasing (or themselves providing) training for each of these groups of staff. Again, the responses have been analysed in terms of the number of times each source of training was reported.

Table 5.4: Sources of training

Source	Nursing (N=57)	Other professionals (N=44)	Unqualified (N=56)
External providers	40	23	32
Own training dept.	39	22	38
College ofNursing and Midwifery/Health Studies	31	13	25
Service staff	5	3	5
Joint HA/SSD training	4	3	3
Other NHS	4	1	4
Not yet decided	5	10	6
None available	1	1	1
Total	129	76	114

External providers of training included a number of agencies specified by respondents, such as the British Institute for Learning Disabilities or BILD (formerly the British Institute for Mental Handicap, BIMH), the Mental Handicap Nurses' Association (MHNA), the Association for Psychological Therapies (APT), Universities and Colleges of Further Education. A prison was also mentioned as providing Control and Restraint training. In addition, respondents referred to the use of outside consultants and specialists, or outside agencies in general. Other NHS providers of training included reference to a Regional Secure Unit and to a Regional Training Team.

The total number of responses compared with the number of respondents indicates that, on average, nearly two sources of training were involved in provision. In detail, 18 respondents purchased training for nurses from the three main sources, eight purchased training from all three for other professional staff and 12 purchased training from all three for unqualified staff.

Again it becomes apparent that a wide range of providers is helping to meet the staff training needs of service providers in this field. Colleges of Nursing and Midwifery/Health Studies are not the largest single providers of training for nurses or for the other categories of staff. In-service education departments and external providers, numerically at least, provide more training in this field than do the Colleges.

3.2 **Types of training**

Given the variety of providers of training, what types of training were being purchased, for which staff groups? Table 5.5 illustrates the responses to these questions.

Table 5.5: Types of training

Type	Nursing (N=56)	Other professionals (N=42)	Unqualified (N=54)
ENB validated	42	15	12
Home Office approved	13	7	8
CCETSW validated	--	1	--
ENB/CCETSW validated	3	2	1
NVQ courses	--	--	6
City & Guilds	2	--	--
Higher Education accredited	13	4	3
Workshops/ short courses	31	18	35
Non-validated	37	23	35
Total	141	70	101

Amongst nurses, ENB validated courses and courses accredited through Higher Education were popular, but short courses and workshops and non-validated courses were also extensively used. The latter were also (numerically, at least) important for meeting the training needs of other professionally qualified and unqualified staff.

3.3 **Purchaser views about training in general**

The general comments provided by respondents about the training they purchased for staff working with this client group provided further insight into the feelings of service managers about the training they purchased. A very wide variety of comments were made (a total of 39), many of which were only reported by one respondent. A tabular form of presentation was not thought to be helpful. In this section the points made are grouped together into similar issues for the sake of clarity.

Some external providers of training were specifically identified as being of a high quality and meeting service and client needs - in this regard BILD courses, MHNA courses and APT courses were each identified by at least one respondent. The cost of externally provided courses was, however, a point of criticism, with the exception of those provided through the APT, which were described as "very good, inexpensive and effective" - and which also were felt to complement the ENB validated courses. The long ENB courses were also described as costly, with a plea that more day release courses would be better from the point of view of the purchasers of training. The limited availability of any training for staff working with these clients was mentioned by six respondents, and the limited availability of ENB course 937 was specifically mentioned by a further respondent. The importance of supervised practice in training unqualified staff was made by two respondents, and the value of alternative experience placements was put forward by another respondent, as being beneficial for all groups of staff. Courses which were too general or non-specific came in for criticism, as did courses which did not achieve change or were not sufficiently competency-based. Other respondents had no criticisms of courses they purchased which were seen to enable staff to be flexible, to become aware of other approaches to similar client needs, to develop confidence and, for unqualified staff, to enable them to be of greater assistance to qualified staff. Professional and personal development was felt in general to be useful, although it "must be consistent".

Given the number of service providers who reported their use of Home Office approved Control and Restraint courses, it is worth reporting that a small number of respondents (two) commented on the importance of non-aversive approaches in general and Gentle Teaching in particular, and a further respondent expressed concern that there could be over-reliance on the physical management of clients to the detriment of more positive approaches to meeting their needs.

The quality of courses as reported was variable - some purchasers were very satisfied, whereas other felt that none of the available courses were of particular value. Yet another respondent noted that some were "very good" and others were "very bad". In evaluating the quality of courses, the most common point made related to the crucial importance of **practical, competency-based training, tailor-made for meeting local needs**. Overall, a total of 33 responses made reference to this issue, 12 in relation to nurses, 9 in relation to other professional staff and 12 in relation to unqualified staff. Examples of such comments include:

> "Courses must of necessity be competency based. The need is for skilled practitioners able to adopt a reflective, problem-solving technique to the client group..... Unfortunately most courses/workshops in the field are sensitising/exploratory only" (in respect of qualified nursing staff).

> "Locally based training is most welcomed as it takes into account being able to relate to actual service provisions" (in relation to unqualified staff).

> [Our in-service education department is] "able to provide the tailor-made information and skills for specific situations looking at the needs, knowledge, skills and assets of the unqualified carers".

Finally, the information on joint and shared training will be provided and discussed.

4 Joint and shared training

4.1 Provider information - survey data

In the questionnaire respondents were asked to give their views on the relative merits of joint and shared training, as separate issues. This design generated some unanticipated responses, identified in the following tables.

4.1.1 Joint Training Table 5.6 indicates the responses to the question about the perceived advantages and disadvantages of joint training.

Table 5.6: Advantages and disadvantages of joint training

(N = 53)

a) Advantages

Broader knowledge/skill and/or philosophy base	29
Breaks down barriers/ promotes understanding	19
Exchange of information/ practice	14
Improves quality/consistency of care	12
Promotes multi-disciplinary teamwork/inter-agency working	11
Cost-effective/reduces duplicity	9
Improves the quality of courses	5
Provides a more marketable qualification	4
Non-nurses learn from nurses	2
None	2
Queried definition/no response	2
Total	109

74

b) Disadvantages

None	12
May dilute professionalism/ too generic	12
Practical difficulties of organising courses + greater costs	13
May confirm prejudices	5
Total	42

The view was expressed that there were no advantages to joint training but mainly respondents identified both advantages and disadvantages to joint training. In fact it is clear from the responses that more respondents reported advantages only, although a small proportion identified only disadvantages. The majority however reported both advantages and disadvantages. The list of discrete advantages is longer than that for discrete disadvantages, although it will be apparent that the specific reasons given were often inter-related.

The primary advantages would seem to be the broader knowledge, skill or philosophy base that this training offers, the breaking down of barriers and exchange of information and practical expertise. The improved quality of care and (related) cost-effectiveness of joint training were also mentioned. Some respondents were concerned however that joint training might lead to the dilution of professional skills and identity. The practical difficulties of organising such courses was also mentioned relatively frequently.

4.1.2 Shared Training Those who were concerned that joint training might undermine professional identities saw the advantages of shared training being in the ability of this approach to offer the advantages of cross-fertilisation of ideas and cost-effectiveness whilst 'still allowing professions to retain autonomy and a clear identity'. Table 5.7 presents these findings in detail. Some respondents simply stated that

75

their answer in respect of shared training was identical to their answer for joint training. In these cases the substance of the responses is given in brackets after the number of respondents who stated that advantage specifically in relation to shared training.

Table 5.7: Advantages and disadvantages of shared training

(N = 53)

a) Advantages

As for joint training	22
Break down barriers/ promote understanding	18 (+6)
Share knowledge, skills etc.	16 (+23)
Improve quality/consistency of care	8 (+4)
Cost effective	7 (+4)
Provides more useful qualification	- (+2)
Queried definition/no response	3
Total	74

b) Disadvantages

None	12 (+1)
As for Joint	9
May dilute profession/ too generic	5 (+4)
Need to bring all students to same level first	5 (+1)
Practical difficulties of organising	5 (+3)
Less good (than Joint) at breaking down barriers	3
Can emphasise differences	3
Cost	2
Definition unclear/no response	2
Total	46

The same types of advantages and disadvantages were identified by respondents in respect of shared training as in respect of joint training. Concerns about professional dilution were less apparent in respect of shared as compared with joint training.

The practical difficulties of arranging shared training were mentioned by one respondent who went on to say that:

> "...the task is easier now that we are having to respond to the purchaser/provider models operating in the care services. From the College perspective the need to sell courses which customers want is the key strategy"

Some responses indicated uncertainty as to the difference between the concepts of joint and shared training. The lack of explicit definitions of the terms joint and shared was commented upon by a small number of respondents who had therefore had difficulty in answering the questions.

Responses from those interviewed and from purchasers of training avoid this problem to some extent by grouping the two types of training under the same heading. Information collected by interviewing providers of training is reported next.

4.2 Provider information - interview data training

All interviewees were entirely positive about the principles of joint training, and all provided courses which were open to and taken up by more than one profession. The aims of cooperative working and shared skill development were unanimously supported, and the distinctions between professional roles seen to be in the main artificial and not helpful to the provision of a quality service to this client group. Interviewees were not supportive of the view that individual professions should be defensive about separate identities and integrity.

Those courses providing jointly validated training had, however, been unable to recruit social workers in any numbers - indeed one course had recruited none and the other only a very small number. The primary difficulty for social services was identified as resources - the cost of the fees for training was not the primary problem, but the cost of providing replacement staffing to cover for those on courses was a major barrier. This was particularly true of the full-time 9-month course. An additional problem for that course was felt to be the inclusion of the phrase 'behaviour modification' in the course title - social workers and social service managers appeared to think that this emphasis was not relevant to social services provision (although in fact the course covered a much wider range of approaches to challenging behaviour than simply behaviour modification).

The long course had recruited only nursing staff, despite promoting the course as suitable for staff with a range of professional backgrounds. The shorter course had attracted staff with other qualifications, including a teacher, a psychologist, two social workers and one unqualified but very experienced residential care officer from social services.

Efforts to develop joint training more widely were not felt to have been very successful - the cost, professional concerns and the additional validation conditions and requirement all contributed to practical barriers to more extensive provision and use of joint training. Given some of the practical difficulties that had been experienced in respect of joint training, the notion of shared training certainly met with approval.

The charitable school and Workers' Educational Association courses both provided training intended for staff with or without professional qualifications, and with a range of qualifications - although the WEA course was seen as complementary to a College of Nursing and Midwifery/Health Studies course operating in the same area. The latter provided training primarily at post-qualifying level, whilst the former was aimed primarily at unqualified staff, volunteers, and informal carers. However, neither course excluded the target students of the other and applications from potential students were assessed on the basis of individual need and the appropriateness of a particular course. The former had developed training initially for its own staff (unqualified and qualified - the latter including general nursing, teaching and social work), but was developing its expertise to provide training more widely, on a consultancy basis.

The primary criteria for acceptance on to all courses was that students would be working with (or in regular contact with) one (or more) people with learning disabilities who exhibited challenging behaviour. All courses were very much practice-based and therefore it was crucial that students would be able to carry out projects in their places of work or in relation to a specific individual from this client group. Secondary to this was a degree of experience which students could contribute to the course which would enable students to learn from the experiences of each other.

4.3 **Purchaser views about joint and shared training**

The final question in the sections on the training which service providers were using sought general opinions on the relative merits of joint and shared training. Table 5.8 presents the comments made by those who responded to this part of the survey.

Table 5.8: Joint and shared training

	Nursing (N=54)	Other professionals (N=43)	Unqualified (N=52)
a) Advantages			
Wide participation	14	11	13
Role clarification	9	8	8
Range of perspectives	26	21	26
Improved quality of care	13	11	16
Promotes multi-disciplinary/ multi-agency work	21	15	18
Advantages not specified	17	7	10
Total	100	73	91
b) Disadvantages			
Role confusion	2	1	2
Practicalities of arranging	1	1	--
Different knowledge/ skills base	4	6	5
Limited specialist skill development	9	5	11
Total	16	13	18

In addition, each of the following points were made by only one respondent, in relation to shared and joint training:

> employment prospects are enhanced by joint/shared training;
>
> the quality of education is what is important, not the discipline of the trainer;

greater availability of joint/shared training would be an improvement;

it is cost-effective;

its value depends on the agencies involved;

unqualified staff sometimes find that joint/shared training is pitched at too high a level, but that the introduction of NVQs should improve the situation.

This information indicates that for the majority of respondents to these questions the benefits of joint and shared training outweighed the disadvantages - again in terms of the number and range of responses in each category. Whilst some remain concerned that this approach to training may dilute or limit the development of specialist skills, the majority saw advantages in sharing knowledge, skills and perspectives which would have beneficial implications for the quality and consistency of care as experienced by the client of services. This concern was expressed in relation specifically to nursing staff, who saw that there were advantages of joint/shared training in that it offered:

> "A better insight into mental illness and mental health needs but one needs to be cautious in not diluting the contents relating to the skills, knowledge and attitude required in working with people with learning disability."

A particularly interesting advantage of shared training was mentioned, by only one respondent, and in relation to other professionals, namely that:

> "Shared training offers the opportunity for mutual understanding, shared models and conflict resolutions which are dealt with on the course rather than around the client".

The value of shared training (presumably 'off-site') here is that disagreements and misunderstandings can be discussed, clarified and resolved without the service user being affected by the process.

One purchaser was very specific that:

> "... the individual worker must be extensively trained and experienced. The discipline, per se, is not important. The quality of the education available is."

This respondent clearly felt that the quality of training was more important than issues of professional identity.

4.4 **Summary**

These data indicate that both purchasers and providers of training see advantages of joint and shared training. The number of survey respondents who reported advantages was greater than the number who reported disadvantages (of either joint or shared training). Those who were interviewed, in both Colleges of Nursing and Midwifery/Health Studies and other training agencies were entirely in favour of a joint approach to training.

Summary and Conclusion

In this chapter material has been presented on the definitions of challenging behaviour adopted by both purchasers and providers of training, and the models of service provided by purchasers of training. The sources and types of training purchased or used by NHS service providers were described, followed by a report of their general views about this training. Finally, information from all respondents on the issues of joint and shared training in meeting the needs of people with a learning disability who exhibit challenging behaviour and may have an associated mental illness was reported and discussed. The data presented, although not to be generalised or treated as definitive suggest that:

a) the generality and variability of definitions of challenging behaviour identified in Chapter 3 are borne out in practice - for both providers and purchasers of training. Very few included specific or detailed types of behaviour as might be exhibited by particular individuals;

b) a variety and complexity of models of service are provided by both Directly Managed Units and NHS Trusts. In addition, the data suggests that, at least as far as this particular client group is concerned, the NHS will continue to be a major provider of services. There was little evidence of substantial withdrawal from service provision and evidence that some NHS providers were intending to extend their services for this client group;

c) very few of those purchasers of training who did respond to the survey made reference to specialised mental health provision (either access to facilities such as hospital beds or access to psychiatric personnel). This seems to support the material drawn from the literature that the recognition of mental illness in people with learning disabilities is not well developed in this country.

d) purchasers used a wide variety of training to meet the needs of staff working with this client group. Although Colleges of Nursing and Midwifery/Health Studies were a major provider of this training, so were in-service training departments and external, non-NHS providers.

e) equally, non-validated short courses and workshops were as popular (numerically) as courses validated by external bodies such as the ENB and CCETSW.

f) although the majority of respondents were very supportive of joint and shared training there was a minority view that professional identity at a post-basic level needs to be defended, and that joint or shared training might undermine this sense of identity.

Overall, in relation to all these points the main themes to emerge are those of variety and diversity - whether of definition, model of service provision or source and type of training purchased for staff working with people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness. In this context it is perhaps not surprising that purchasers of training who responded to the survey identified the following characteristics of training as particularly valuable:

practical and competency-based;
outcome oriented;
responsive to local client, service and staff needs.

The next chapter reports the material on standards of competence and of courses, and on skills sought from staff working with people with learning disabilities who exhibit challenging behaviour and who may have an associated mental illness.

CHAPTER 6

PURCHASER AND PROVIDER INFORMATION: SKILLS AND STANDARDS

Introduction

The last chapter concluded with reference to the diversity and variety of meanings, service models and training provision, and the importance of training to meet local needs. This chapter will look at the specific issues of:

a) standards of competence on the part of course participants and of comparability between courses.

b) skills identified by both purchasers and providers as desirable for staff working with this client group;

Under each of these headings, information collected from all three sources will be described, in the following order:

the information provided by those training providers who completed the questionnaire;

the information provided by those training providers who were interviewed;

the information provided by those purchasers of training who completed the questionnaire.

The views of these respondents in relation to standards are described and discussed next.

1 Standards of competence on the part of course participants

In this section the data collected from all three sources will be presented, and in the same order. In view of the concerns expressed by purchasers about the variable quality of training for staff working with people with learning disabilities who exhibit challenging behaviour on the part of some respondents, the material on determining standards of competence on the part of course participants is of particular interest.

1.1 Training provider information - survey responses

First, the data on setting standards on the part of individual students within courses provided by those training providers who completed the questionnaire is presented in Table 6.1:

Table 6.1: Standards of Competence (providers)

(N = 55)

Should be set by:	N
Professional/validating bodies	18
Qualified assessors	14
Practitioners and tutors	13
Tripartite	7
Clients	6
NVQ/Competency-based	6
Academic assessment	5
Practitioners only	5
Self-assessment only	1
Other	3
Total	78

The professional validating bodies were the most frequently mentioned resource for setting standards of competence on the part of course participants. That standards should be practice-based and related to the workplace and service requirements was equally a frequent response. The notion of a 'quality assurance framework' for setting standards was also suggested. The role of service users and informal carers in this context also emerged from a number of respondents.

A number of these points were made by the following respondent:

> "The ENB Framework and Higher Award offer a logical and systematic approach to higher and further education. There would have to be evidence of real

change and education staff would be involved in the assessment process"

1.2 Training provider information - interview data

The interviews gave opportunity to investigate the approach that a small number of training providers took in relation to standard setting in some depth, and this information is similarly reported in detail. They were dealing with the subject of standard setting in a number of ways. The different approaches to standard setting which were adopted and the issues arising are described below.

1.2.1 The College of Health/Higher Education course (ENB 705/CCETSW PQS/79). External standards for this course were validated by the national bodies for the nursing and social work professions. This course emerged from a Regional group of service providers who identified this area as a shortfall in training provision. Once the course content and structure had been agreed however, the validating bodies have not been involved in assessing standards of competence on the part of individual students. It was felt that this was an area which could be improved - there had been an attempt to rate students on a 1-5 scale of competence, but this had proved too detailed for supervisors. Practice supervisors were asked to provide written comments on the students' knowledge and practical competence, but this was not completely satisfactory and this area was to be further developed.

Other contributions to standard setting were made by local service providers and managers. Proposals for this course emerged from discussions at a Regional Training Group, which included representatives from the constituent DHAs. The DHAs are also represented on the Management Group for the course, and practice supervisors also make an input into the course and give feedback on local service needs and competencies required. The role of practice supervisors in developing standards and assessing individual students' competencies was fundamental to the course. Finally in respect of this course, there were plans to develop it as a Diploma to be accredited and awarded by the relevant University, but this was still at the discussion stage. There were also plans to develop this course in terms of CATS points - the present course was being submitted for accreditation by the University as a Diploma course which might attract 120 points at level 2.

Overall the course tutor was of the view that the development of measurable competencies in a course of this nature was an ongoing task faced with a number of difficulties. The primary difficulties were thought to be:

a) the variety of client needs with which students would be expected to work - ranging from relatively able offenders to people with multiple and profound handicaps as well as challenging behaviours;

b) the variety of settings from which students came - working for different employers, with different structures and with different philosophies.

These issues were raised by this particular course, which recruits students from a number of agencies coming from a relatively wide geographical area. They are equally likely to be relevant for training students to comparable standards who are attending different courses.

1.2.2 The College of Health course (Professional Development: Understanding and Working with Challenging Behaviour) was at the time of the interview validated by the Board and CCETSW, and accredited by another institute of higher education. The College was developing its post-registration courses to fit in with the modular format of degrees and other awards - the post-registration courses in learning disabilities, including NO2, were being developed and amended to come in at the level 3 module on Professional Development, and will be offered in the context of the ENB Higher Award. These courses would be introduced in 1993. In due course, these modules could then be undertaken as part of a nursing/health/psychology degree. They could be taken as part of a first degree, or as 'one-offs' which would each accumulate 20 CATS points. Courses at present just offer a Certificate of Attendance, but it was anticipated that when they are offered at level 3 successful completion will contribute to the Higher Award, and attract CATS points.

In due course, the tutors may look to offering courses in this area at level one, to meet the needs of staff for whom the course will be appropriate and who are likely to benefit from the course but who may not want, or have the necessary academic skills, to complete the written assessments. When offered at level 3, it may be necessary to offer some additional pre-course study skills training for students. The issue of Accreditation of Prior Experiential Learning or retrospective CATS points is also to be addressed - it may be that students could rework the projects they have done for the Statement of Attendance in order to have their attendance accredited at level 3. Interestingly, the course was developed by Nurse Education and Psychology working together.

1.2.3 The WEA course was not validated by any professional body (being targeted primarily at unqualified staff or volunteers and at informal carers) but was accredited by a Polytechnic. The agreement required that students must have completed all assessments, which are based on practical work with individuals. The course was accredited at level 3 of the Council for National Academic Awards model of CATS points for students who had reached that level, with the potential for completion at level 1 or 2 if appropriate (McManus, 1991). The Polytechnic had been prepared to be very flexible, and had provided a liaison person to deal with issues that have arisen.

On standards of competence the course tutors worked to the following general criteria:

Projects for assessment must be prepared and presented in a manner that is comprehensible to the person to whom the work relates (all assessments are related to individual clients who have learning disabilities and exhibit challenging behaviour). This implies that for most students media other than, or in addition to, the written word will be chosen for the assessments - such as video or photographic media.

The outcomes of participation on the course are expressed in terms of individualised learning, with the major emphasis on effectiveness in practice - what changes have occurred in this student's understanding of and consequent relationship to and work with individual people with learning disabilities who exhibit challenging behaviour.

1.2.4 The Independent School was developing its training in terms of NVQ competencies - the School is playing an important role with the local consortium to develop NVQ standards of competence in this area of work, for unqualified staff at levels 1 and 2. The head of the school was a qualified teacher with extensive experience of special needs education in the statutory sector. She had additional training in **Strategies for Crisis Intervention and Prevention** (originating from the New York State Office of Mental Retardation and Developmental Disabilities). The Direct Care Competency Manual provided from this source was the basis for the work they were doing to develop NVQ competencies.

The School also placed a very high value on quality - of both services and training - and was developing its own internal quality management procedures where a constant process of review of both child and staff development would take place. Through the NVQ approach standards of competence between courses and of staff taking their courses will be set. Constant supervision, assessment and staff appraisal were further means of ensuring a continuous and consistent approach to quality of provision within the school.

1.3 Standards of competence - purchasers of training

Table 6.2 presents the various responses on how standards of competence on the part of trainees should be determined, and by whom.

Table 6.2: Standards of competence (purchasers)

(N=50)

Should be set by means of:	N
Continuous assessment	12
NVQ assessors	4
Contract process	3
Quality assurance systems	4
Supervised practice	4
Changes in practice	4
Total	31
Should be set by:	
Managers/practitioners and educators	11
Internal & external trained assessors	7
Local practitioners/managers	4
National professional/validating bodies	3
Mentors/tutors	5
National & local validating bodies	1
Service users	1
Total	32

A variety of methods and arbiters of standards of competence were reported, but it is clear that these respondents saw a major role for service managers and practitioners in the standard setting process. Local purchasers of training saw a role for themselves and local practitioners either through supervised practice, through quality assurance systems or through the contracting process. One of the suggested methods whereby standards would be assessed was through changes in practice, with one respondent referring to the use of pre-course and post-course testing as a specific means of assessing standards of competence. A role was identified for national professional and validating bodies by some respondents, but these agencies did not figure prominently on the part of those who responded to this survey.

The following list of methods of standard setting were identified by one purchaser:

> "1. By effectiveness of service. Numbers of people being able to return to local services.
>
> 2. Reduced admission rate to hospital
>
> 3. Staff turnover rates, staff appraisal and supervision carried out by a range of people in the services".

This illustrates the variety of standard setting mechanisms identified, and the importance of practical outcomes for training purchasers.

1.4 **Summary**

The survey of training providers indicated that the national professional and validating bodies had a major role to play in setting standards of competence on the part of course participants. One of the course tutors interviewed felt however, that the validating bodies made less of a contribution at the level of assessing competencies of individuals as opposed to validating the course as a whole. The former task had proved to be difficult and was still under development. Providers of training also identified a role for practitioners in setting standards of competence as did the purchasers - who also mentioned the contracting process and the role of service managers in monitoring the outcome of training. The NVQ approach was supported by both providers and purchasers, as was the importance of supervised and assessed practice. The tutors of three courses were looking to develop their courses within the model of CATS, and both Colleges were intending that their courses should fit into the Framework for the Higher Award.

The next section provides information on the question of course comparability at a national level.

2 Standards of course comparability

The expressed demand on the part of purchasers for training to meet local and specific needs reinforces the importance of setting standards of comparability between courses to ensure that training in one area will not be irrelevant to meeting the needs of clients as and when staff or clients move to other services.

2.1 Providers of training - survey data

The preferred response of the survey respondents was that some central body/ies should take this responsibility. Table 6.3 gives this information in detail.

Table 6.3: National Standards (providers)

(N = 54)

Should be set by	N
Validating bodies	18
Academic bodies	11
Joint boards	9
National curricula	4
NVQ	4
Education providers	3
Purchasers of services	4
Regions	3
External assessors	3
Consumers	2
RCN	1
UKCC	1
DH	1
Service providers	1
Queried the need to have	3
Total	68

Again the national validating bodies were identified by the largest single group of respondents. Alternatively, the professional training departments in institutions of Higher Education were suggested, again with reference to quality assurance mechanisms. It was also suggested that it was 'likely that Regional Health Authorities as purchasers of training would wish to play a large part in standard setting'. Properly financed research projects were identified as another approach to standard setting. A note of caution was also sounded, with the view that practice competencies should not be viewed simply as 'tasks', because they often have a theoretical rationale. Finally, some respondents queried the need for standard setting at all - although this was very clearly a minority view.

The following quotations illustrate some of the above points:

> "...purchasers are the people who are best placed to determine and evaluate the standards ...., this will normally be evident in outcome competencies achieved by course students....teachers and service agencies forming educational consortia".

and:

> "Higher education offers common currency via CAT and APEL and new learning that is recognised across the country. Modules can provide sizeable "bites" to meet consumer needs at appropriate levels".

The potential role of higher and further education is made clear here, as is the importance of purchasers working together with educators in setting standards.

2.2 **Standards of course comparability - purchasers of training**

Given the move towards local training to meet local service needs mentioned previously, the information from respondents on the setting of national standards is of substantial interest. The data are presented in Table 6.4.

Table 6.4: National Standards (purchasers)

(N=45)

Should be set by means of:	N
Contract process	7
Standardised modules	3
CATS	3
Continuous assessment	2
Changes in practice	1
Total	16
Should be set by:	
National professional/validating bodies	18
Managers/practitioners and educators	6
National & local validating bodies	5
Joint validating bodies	2
Internal & external trained assessors	1
Not known	2
Total	34

The contract process was also favoured as a means of setting national standards, and the idea of standardised modules and the CATS system were also mentioned. The national professional and validating bodies were most frequently mentioned by these respondents as the agencies whereby such standards should be set, but again local practitioners, educators and local validating bodies featured highly in the remaining responses.

The variety of responses is illustrated by the following:

> "1. Someone attending all courses and reporting back on effectiveness
> 2. Discussion with participants
> 3. Staff confidence
> 4. Discussion with service users about different approaches"

and:

> "A national drive to set standards in this area could

> be led by a body such as the ENB but with input from social services and voluntary bodies would be a good starting point"

The reference here to a potential role for the ENB is of particular interest, and indicates one area where the Board could take a lead.

2.3 **Summary**

The national validating bodies were seen to have a part to play by the majority of both providers and purchasers of training who responded to the survey. Again, NVQ and the CATS scheme were seen as important contributors by both parties. Managers, practitioners and educators were all identified as having a part to play in this process.

3 **Skills sought for working with this client group**

The information from all sources about the skills sought from staff working with this client group are presented - again in the same order. First, the survey responses from providers of training.

3.1 **Providers of training - survey data**

Respondents were asked what skills they thought were desirable for three categories of staff working with this client group. The three categories of staff were qualified nursing staff, staff with other professional qualifications and staff with no professional qualifications. Table 6.5 presents the data collected in response to this question.

Table 6.5: Staff skills sought (providers)

	Nursing (N=49)	Other professionals (N=49)	Unqualified (N=46)
a) Skills			
Interpersonal/ communication/ counselling	41	22	14
Behavioural techniques	24	13	17
Personal qualities	11	7	14
Assessment/observation/ recording	16	8	7
Physical management	13	8	7
Teaching/training	12	5	5
Planning	11	2	2
Ethical/legal	8	4	2
Specific to need/role	--	8	3
Non-aversive	4	3	3
Functional analysis	4	1	1
Clinical/mental illness & learning disabilities	7	--	--
Evaluation	6	--	--
Advocacy	3	2	1
Mental illness/learning disabilities	--	3	2
Other services	--	5	--
Implementation	4	1	--
Multi-disc. working	2	--	1
Staff management	2	1	--
Psychotherapy	2	--	--
Other	1	--	8
Total	170	93	87

b) Acquired by:			
Reflective practice	9	2	--
Work-based practice	--	3	--
Supervised practice	--	--	10
Competency-based	3	4	--
NVQ	--	--	9
Role modelling	--	3	3
Short courses/ workshops	5	2	6
Building on pre-registration	8	--	--
Other educational	3	3	3
Total	28	17	31

These data indicate that a wide diversity of specific and general skills are expected from all categories of staff. Twenty-four respondents simply specified that skills sought in other professionals were the same as those sought from nurses, and 20 respondents reported similarly in respect of unqualified staff - with the proviso that these skills would be at a lower level than expected of professional staff by whom unqualified staff would be supervised. The importance of practical-based skills, developed in the work-place for all categories of staff is noteworthy, although there was some place for formal training provided by educationalists.

As far as the individual staff groupings are concerned, some respondents specifically referred to the 1982 RNMH syllabus as providing a grounding in basic skills for working with these clients, but also specified that pre-registration training in itself was not adequate to enable nurses to take responsibility for providing services for them. Not all respondents felt that particularly distinctive skills were necessary for nurses working in this field. For other professional staff the need was generally felt to be similar, and the idea that any one profession might have a monopoly of skills was rejected. A combination of nursing and social work skills was suggested as a 'good mix'. Some queried the validity of the questions posed in this separate way - in that the skills related to the role and function of the staff members rather than their profession. On the other hand a small number of respondents specified different skills that other professions might bring such as family therapy skills (from social workers) and rehabilitation skills (from occupational therapists).

Similar skills, although at a 'lower level' of competence were thought to be required from unqualified staff. Again, NCVQ was thought to have a role in informing the definition of and framework for competencies in unqualified staff. Two respondents stressed that unqualified staff, whilst being able to carry out behavioural programmes with supervision should never be given the responsibility of designing programmes or of planning strategies.

Some examples of the views of these providers of training are included next.

On the desired skills of qualified nurses:

> "The nurse needs a firm knowledge base of conditions, psychology, sociology, assessment, intervention strategies, team and family work, and problem solving abilities to select and apply these strategies according to the circumstances".

On the relationship between pre-registration and post-registration training it was argued strongly that:

> "pre-registration [nurse] training does not fully develop these skills and it should and could. .... The ENB/UKCC must move from its present narrow focus on this whole area. Nurses can make an important and essential different input to 'care' provision. ...Social workers will take on and over this role unless a more realistic, modern and necessary focus is taken".

On the balance of professionally qualified and unqualified staff skills it was argued, equally clearly, that:

> "The role of the professional is in the scientific assessment, planning and evaluation of care, of the non-professional in its implementation".

3.2 **Skills sought - providers of training (interview data)**

These providers of training approached the subject of skills and philosophy of care in different, although not dissimilar ways.

3.2.1 The Independent School was, as indicated previously, very enthusiastic about approaches taken from North America. Their practical skills training was, at the time of the visit, very much based on the New York state programme for the prevention of challenging behaviour, with use of the 'soft touch' approach to restraint only as a last resort. Their approach also drew on the positive programming model of LaVignia (1989), starting from a functional analysis of behaviour. They also promoted the concept of positive touch (particularly with autistic children who tend to withdraw from or resist physical contact), to the extent that each day began with massage. This positive touch was promoted as a counter to controlling touch, which is only used as a last resort. Controlling touch in this approach was described as 'soft touch' and was very different from the techniques taught in the Control and Restraint courses. The training was carried out by means of role play and supervised practice. Other complementary techniques such as aromatherapy were also employed.

In addition to formal courses for their staff, particularly induction courses for new staff, their emphasis was heavily on the notion of continuous learning. In-service training in the work setting was ongoing, with regular monitoring and staff development programmes.

3.2.2 ENB 705 course - Behavioural Approaches for Professionals working with people who have learning disabilities identified the general skills taught to students on this course as:

assessment
planning
writing effective interventions
building relationships - with clients, carers and colleagues
communication (written and verbal), including formal presentations and receiving feedback on assessments.

The course began with a six-week academic block, during which students covered the following:

* a theoretical understanding of historical and contemporary models of human behaviour, including concepts of adaptive and maladaptive behaviour, and standards against which behaviour is measured;
* staff-client interactions and the values which govern interactions;
* the benefits and limitations of behavioural technologies, including ethical issues;
* assessment procedures, data collection and interpretation;
* developments of interventions and barriers to effectiveness;
* problem solving with teams, clients, families and staff;
* organisational issues of power and leadership;
* basic research methodology;
* compassion fatigue and staff burnout.

The course tutors felt that all qualified staff (regardless of the specific qualification) need a broad range of management and administrative skills as well as skills for direct work with clients. In addition, qualified staff were responsible for assessing behaviour and designing programmes, as well as the day-to-day work with clients. Unqualified staff on the other hand did the greater part of the day-to-day work, implementing the programmes. The exact distribution of skills as between professional and unqualified staff was dependent on the particular local services in which staff were working.

Reference was made to the importance of Gentle Teaching which was felt to be particularly effective to help students understand their own (and others') values and attitudes and how these affect relationships. The issue of values was addressed specifically on the first day, and then integrated throughout the course. Students returned to these subjects as the course progressed, both formally and informally. Similarly, with 'non-aversive techniques' students were introduced to these concepts and issues, and helped to come to their own conclusions through discussion.

At the time of the visit there had been no means for ex-students of the course to meet to discuss progress since or issues arising from their completion of the course and implementation of what they had learnt. In addition, there were no formal mechanisms for feedback from students after the course had ended. This was felt to be an omission and steps were being taken to enable such a meeting to happen.

3.2.3 The College of Health course, (ENB NO2) placed the emphasis on understanding and working with challenging behaviour. The basic principles of this course were derived from the King's Fund arguments that people with challenging behaviour should not be excluded from services based on the same principles as apply to other client groups. Challenging behaviour clients had been thought to be 'too difficult' for full community services, but they were developing an holistic approach to training which emphasised the positives about clients, tried to understand the reasons for behaviour and enabled staff to empathise. The course did include behaviour modification, but also included critiques of the traditional approach. NO2 emphasised:

gentle teaching
non-aversive techniques
relationships
reflectiveness

emphasising the positives in people
O'Brien's 5 accomplishments

The tutors emphasised 'working with' people rather than 'doing things to' them - giving staff permission to get more involved with clients, whilst still retaining the professional relationships. The course was founded very much on the basis of experience, reflection and relationships, which it was felt extremely important to retain when the course is developed as a level 3 course for accreditation purposes.

The learning disabilities section of this College was developing four courses for accreditation at post-registration level, with a view to these being available as part of the Higher Award. In addition to the one under discussion here and an existing course on 'Principles of care for people with a learning disability in Community, Residential and Day Services', two new courses were being developed to provide training about Caring for People with learning and physical/sensory disabilities, and Mental illness in people with learning disabilities. The latter course is of particular interest in this context particularly as it has been developed in response to demand from service providers. Details of these new courses are, however, still to be finalised.

Again, it was felt that there was a need for short 'refresher' courses - but the details of these, and the level at which they might be pitched had not yet been addressed

3.2.4 The WEA course again concentrated on understanding the reasons for challenging behaviour, and on developing skills and strategies for working with this client group. Each student on the course worked with a specific individual client or relative who has a learning disability and exhibits challenging behaviour. The course was modular and covered the following areas:

A Individual Growth and Development - a personal and emotional emphasis, in which a great deal of disclosure is required;

B Designing Services for Individuals - the intellectual and understanding perspective which again starts with the individual students and what meets their own needs, and looks at traditional models and current practices;

C Effective Communication - the creative element of the course in which students test out different ways of communicating with clients to find out what forms of interaction are effective and to widen the relationship.

Module A included some work on mental illness in people with learning disabilities. In addition the course covered functional analysis, behaviour modification, gentle teaching, aversive as compared with non-aversive techniques, 'alternative therapies', communication skills, counselling and creative approaches to communications. The objectives of the course were that students should develop:

* a broad understanding of people, their needs and ways of working with this client group;
* specific expertise with an individual.

There has been a great deal of sharing within groups - of experience, expertise and approaches to problem solving. The focus of the course was very individualised, and aimed to promote students' abilities to take responsibility for their own development and learning. Some elements of specific skills training on this course has additional applications - enabling students to be more assertive, manage stress and their time more effectively when they return to their own place of work or setting.

Parents had been a particular asset to the course, especially by sharing information and insights of how challenging clients are at home. The course tutors felt very strongly that training courses such as this should not be job or role specific, and the involvement of parents was one demonstration of the inappropriateness of an exclusive approach to meeting the needs of this client group.

Yet again, the ongoing needs of students from these courses were recognised - to promote further development after completion of the course follow-up meetings were arranged, partly to enable students to share experiences and also to provide support for each other in their ongoing work.

Unfortunately the original charitable funding for this course has now come to an end, and further courses will not be provided from this source. However, limited funding has been made available so that the course tutors can develop and publish a training package which will enable other trainers to use this course. This comprehensive package will include handbooks for:

managers
tutors
students
and a record for user involvement.

In addition, a marketing booklet for the course will be developed.

3.3 **Skills sought - purchaser data**

The information provided by respondents about the skills sought from the three categories of staff are presented in Table 6.6.

Table 6.6: Staff skills sought (purchasers)

a) Skills	Nursing (N=54)	Other professionals (N=48)	Unqualified (N=50)
Interpersonal/ communication/ counselling	33	26	32
Assessment/observation/ recording	28	18	25
Behavioural techniques	30	16	21
Ethical/legal	16	14	17
Physical management	13	10	11
Mental illness/learning disabilities	--	18	18
Range of techniques	--	20	--
Clinical/mental illness & learning disabilities	22	--	--
Non-aversive	6	8	3
Multi-disc. working	17	1	1
Planning	18	1	--
Teaching/training	15	--	--
Functional analysis	6	4	4
Staff management	11	8	--
Family therapy/ psychotherapy	5	6	--
Specific to need	3	2	3
Depends on role	--	7	--
Fill gaps left by nurses	--	4	--
Other services	--	3	--
Alternative therapies	2	--	--
Total	225	166	135

b) Acquired by:

Supervised practice	--	--	22
Theoretical & practical	20	--	--
NVQ	--	--	18
Experiential learning	18	2	--
Formal courses	--	11	3
Building on pre-registration	4	--	--
Joint training with nurses	--	5	--
Total	42	18	43

This table indicates the diversity and complexity of skills which respondents identified as desirable in staff working with this client group. For the sake of clarity, the table has amalgamated skill groups, so that for instance, counselling and communication skills have been included with inter-personal skills, although some respondents identified these separately. As with providers, respondents who identified the same or similar skills for unqualified as well as for any qualified staff specified that the level of competence expected from the former would be lower than that expected from the latter. So, for example, observation/recording was much more frequently mentioned in respect of unqualified staff than qualified, whereas observation/assessment was more likely to be mentioned in respect of qualified staff.

The most frequently mentioned skill group was that of interpersonal skills. Following from that, assessment, observation and recording skills were mentioned, followed by specific reference to behavioural techniques. A grasp of values, ethics and legal aspects of care were also highly rated. The physical management of aggression and violence also received substantial mention. The need for an understanding of both learning disabilities and mental illness on the part of non-nursing staff was an important element, whereas clinical nursing skills in relation to both client needs were frequently mentioned. Of the 18 respondents who reported specific nursing skills in this context, half identified the dual qualification of RNMH and RMN as desirable. One respondent suggested that the introduction of Project 2000 in nurse training might give registered nurses in either the mental handicap or mental health branches a broader understanding of both types of client need than the single focus of traditional training.

Less emphasis was placed on non-aversive techniques, teaching or training, and functional analysis. In view of the developments in thinking about the causes of challenging behaviour in people with learning disabilities reported in Chapter 4, and the concerns expressed by some training providers that there was a danger of an over-reliance on traditional behavioural techniques and the physical management of aggression, these findings might be seen as a cause for concern. Some purchasers of training were, equally, concerned on this issue, as the following quotation suggests:

> "The S.H.A. course on Control and Restraint is useful but there is potential not to develop other therapeutic techniques/skills and rely too heavily on those methods of 'managing people'. I am keen to avoid this happening".

One of those who did mention the need for skills in relation to both learning disabilities and mental illness was quite specific about this as a training need:

> "Skills in assessing the existence of psychotic illness have been identified locally as a major need. Skills required to provide maximum involvement and interaction in daily living environments are also essential, ie., How much 'challenging behaviour' derives from boredom, lack of purpose and a sterile environment? What are the components of a therapeutic environment?"

Given the material in Chapter 4 on service models, it was also interesting to read the following, which specifically linked service models with skills needed:

> "...., depending on the service model (containment as opposed to ordinary life) carers need a variety of skills and in-depth knowledge base".

3.4 Skills sought - summary

Not surprisingly, in view of the range of therapeutic approaches identified in Chapter 4, a wide range of skills were reported as desirable. In both surveys behavioural techniques were not the most frequently cited set of skills sought. In both cases, interpersonal, communication and counselling skills were most frequently mentioned, with the purchasers also giving higher priority (in numerical terms) to assessment and observation skills. Clinical skills in relation to both mental illness and learning disabilities also figured quite strongly, at least as far as nursing staff were concerned. The value of dual training (RNMH and RMN) was specified by a number of respondents. A general understanding of the two was also mentioned in relation to other professionals and unqualified staff - but more frequently by purchasers than by providers of training. The physical management (including both de-escalation of aggression and restraint/breakaway techniques) also featured strongly in both surveys. Functional analysis was identified as a desirable skill, but not by as many respondents. Training in non-aversive techniques and gentle teaching, in the ethical and legal issues involved in working with this client group, advocacy, psychotherapy and alternative therapies were also mentioned, but less frequently.

The course tutors and trainers who were interviewed included reference to traditional behavioural approaches, but also included critiques of those approaches. The non-aversive or positive programming type of behavioural approaches were more highly favoured, and much concern was expressed that 'Control and Restraint' skills might be seen as a quick and inexpensive response to incidents of challenging behaviour. The principles of Gentle Teaching were also taught on these courses, particularly the importance of values and relationships between 'staff' and 'client' in meeting these needs was also strongly supported. Particular attention was paid to assessment of causes and understanding the functions of behaviour.

Summary and Conclusions

In this chapter the data collected from all three sources of data have been presented in respect of opinions of joint and shared training; setting standards of competence and course comparability; and the skills sought from staff working with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness. A number of common themes emerged from the interviews with training providers, which can be summarised thus:

a) the subject of mental illness did not figure as a major component of any courses, although all touched upon the subject to a greater or lesser extent;

b) one training provider was developing a new course specifically on mental illness in people with learning disabilities, as a response to demand from service providers;

c) all courses identified the need for ongoing support and development to be available for students who had completed their course;

d) all were working closely with service providers and managers to ensure that skills taught were relevant to the needs of the services - although concern was expressed by one provider that in the pressure to contain costs service managers might be tempted to concentrate on cheaper, though ultimately less effective control and restraint or other reactive techniques for working with challenging behaviour;

e) all courses were giving a high priority to functional analysis and understanding the reasons for challenging

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behaviour - and most were concerned to promote an understanding that 'challenging behaviour' was not something peculiar to people with disabilities, and that anyone might adopt behaviour that was not fully socially acceptable.

f) courses were, again to a greater or lesser extent, moving away from traditional behavioural techniques to a concentration on non-aversive techniques, gentle teaching and alternative approaches to communication.

g) all training providers were developing courses in response to demand from service providers, and courses which emphasised the importance of thorough assessment to meet individual needs.

Before identifying the main points emerging from this work, the caveat regarding the nature of the data should be repeated. The response rate, particularly to the purchaser survey was relatively low, and consequently these points should be seen as indicative of the sorts of issues arising rather than as firm and general conclusions. With that caution in mind, the main themes which have emerged from this work with providers and purchasers of training are:

a) the importance of service providers and users in setting standards was also identified, in addition to the anticipated reference to professional validating bodies and providers of training;

b) an appreciation of mental illness has not emerged as a major area of training in respect of people with learning disabilities who exhibit challenging behaviour, although some of those interviewed were identifying this as a need to be filled;

c) there seems to be a growing interest in approaches to challenging behaviour which are non-aversive and based on the principles of 'an ordinary life'. Again in the interview material the emphasis was on control as a last resort with understanding, communication, prevention and functional analysis being the preferred approaches;

d) the range and breadth of skills sought from all professional and unqualified staff was extensive. General skills such as interpersonal, communication and counselling skills, assessment and planning were highly valued, as well as skills specific to behavioural techniques. There was also evidence that clinical nursing skills in both mental illness and learning disabilities were valued, and the dual registration (RNMH and RMN) was specified as desirable by a number of respondents;

e) one of the course tutors interviewed was already addressing the issue of developing post-registration courses for the ENB Higher Award. Some concerns were expressed about this move to more academic training, and whether it would be possible to run the course at both level 1 and level 3, to meet the needs of students with less academic interests. The issues of awarding retrospective CATS points was also under discussion, in relation to students who had recently been awarded the Statement of Attendance.

Some of the points made above would seem to be consistent with the material identified in the literature review, particularly Chapter 4. The relatively recent emergence of a recognition of mental illness in people with learning disabilities, and the variety of approaches to meeting the needs of people with learning disabilities and challenging behaviour are both supportive of the conclusions drawn from the literature review. In addition, the implementation of 'the contract culture' identified in Chapter 2 is having an impact. The role of service managers as purchasers of training and the introduction of quality assurance mechanisms through the contracting process were important elements in the setting and evaluating of standards of competence on the part of course participants and of standards of course comparability.

SECTION III

Directory of Courses

CHAPTER 7

DIRECTORY OF TRAINING COURSES IN ENGLAND

Introduction

This Directory is presented in four Sections. Section I includes the information collected about courses accredited and validated by one of the main professional bodies - the English National Board, the Central Council for Education, Training and Social Work, the British Psychological Society, or by CNAA. The letter sent to Regional Health Authority Directors of Nurse Education also requested information about the post-registration and post-qualifying courses on the subject of working with people with learning disabilities who might have an associated mental illness and who exhibit challenging behaviour. Their responses are included. Information provided by repondents to the survey of Colleges of Health/Nursing is also included in this section.

The format for presenting the information about existing, externally validated courses is as follows:

TITLE - the title of the training course

COORDINATOR - the person responsible for running the course, where available

BODY - the name of the institution

SUMMARY - includes information about:

course length
course format
target student group
admission requirements
award
course content
validation

NOTES - any additional comments about the course.

In addition to information about validated courses respondents also reported the provision of short courses and workshops provided by in-service training departments and which are not validated by the professional bodies. This information is presented in Section II. Section III includes information from the postal survey on courses which were planned by those who responded to the survey. Finally, Section IV lists some agencies other than Colleges of Health/Nursing who provide training. The details of courses have only been provided where still current, but examples of relevant courses which have been offered in the past are given.

Each section begins with a list of the courses or Colleges included.

At the end of the Directory some issues arising from the material included have been brought together.

SECTION 1 - VALIDATED COURSES

1 List of courses

Behavioural Approaches for Professionals Working with People who Have Learning Difficulties

ENB Course NO2: Understanding and Working with Challenging Behaviour

ENB Course 937: Behaviour Modification in Mental Handicap Nursing for Registered and Enrolled Nursing

ENB Course 705: Behaviour Modification in Mental Handicap Nursing

ENB Course 770: Nursing in Controlled Environments for Nurses on Parts 3 (RMN) or 5 (RNMH) of the Professional Register

ENB Course 939/993: Care of People with a Mental Handicap/Mental Illness in Community Residential and Day Care Services

ENB Course 807: Nursing People with a Mental Handicap/Learning Difficulty in the Community for Nurses on Part 5 (RNMH) of the Professional Register

ENB Course 955: Short Course on the Care of the Violent or Potentially Violent Individual

ENB Course 935: Advances in Mental Handicap Nursing for Nurses on Parts 2 (EN), 4(ENM) or 6 (ENMH) of the Professional Register.

ENB Course 936: Developments in Mental Handicap Nursing for Nurses on Part 5 (RNMH) of the Professional Register

ENB Course A12: Cognitive Behaviour Therapy

Diploma in Social Learning Theory and Practice (ENB Course A02)

MA in the Applied Psychology of Mental Handicap

TITLE:	Behavioural Approaches for Professionals Working with People who have Learning Difficulties
COORDINATOR:	E Veronica (Vicky) Bliss
BODY:	Hester Adrian Research Centre (University of Manchester)/Lancaster College of Nursing, with Health and Social Services in the North Western Region
SUMMARY:	Length 36 weeks (Sep-June).
Form	modular pattern, six weeks of theoretical instruction preceding four six-week blocks of related practical experience placements.
Aimed at:	professionals with any relevant qualification (eg CSS, CQSW, RNMH or degree) practicing in a variety of fields, education, psychology, nursing or social services.
Admission requirement	(i) relevant professional qualification (ii) experience of working with people with learning difficulties (iii) secondment with a promise of post-course support from employing authority managers.
Award by	ENB Certificate in Clinical Practice. Students Institution with suitable nursing qualifications willreceive a certificate for the equivalent of the **ENB 705** course, (Behaviour Modification in Mental Handicap Nursing for Nurses on Parts 1 (RGN), 3 (RMN), 5 (RNMH) or 8 (RSCN)) on completion. Also recognised as post-qualification course by CCETSW, **PQS/79**.
Content:	Programme aims to provide students with theoretical and clinical skills in behavioural change, prepare practitioners to devise, implement and evaluate appropriate interventions, build familiarity with range of behavioural theories and techniques, enable students to act as future "challenging behaviour consultants" and to introduce practitioners to the value of research.
Validation:	Jointly validated by the ENB and CCETSW. Validated through East Lancashire School of Nursing and the Hester Adrian Research Centre, University of Manchester.
FUNDING:	The course is partly funded via the North

Western Regional Health Authority through services for challenging behaviour at Calderstone in Whalley, the remainder made up by tuition fees.

NOTES: Although aimed at a wide range of professionals, to date has only attracted nurses. Running since May 1989.

A new component of the course is the introduction of "lectures on basic statistical concepts and a broadening of principles of behaviour change which may be used with people who have mental illness"

TITLE:	Professional Development: Understanding and Working with Challenging Behaviour
COORDINATOR:	Melissa Laird
BODY:	Avon College of Health
SUMMARY:	
Length:	30 days over 85 days.
Form:	30 days of theoretical study, integrated with practical experience.
Aimed at:	nurses holding RNMH or ENMH certificates and to other suitably qualified staff (eg. CSS, CQSW, Cert. Ed, relevant degrees/diplomas, or professional qualifications).
Admission requirements	as above, preference given to applicants who work with clients with severe challenging behaviour.
Award by Institution	ENB Statement of Attendance.
Content	covers: developing self-awareness; the causes of challenging behaviour; assessment of clients; behavioural approaches and critical evaluation of traditional behaviour modification models of care; cognitive counselling and gentle teaching/non-aversive therapies; psychotherapy, family therapy & cognitive therapy; psychiatric disorders; supporting the careers and staff training; assessment, planning implementation and evaluation of care on an individual basis.
Validation:	ENB **NO2** and CCETSW **(PQS/87)** approved.
NOTES:	Course reviewed in Nursing Oct 25-Nov 7, 1990, 4:21, 21-23. Learning packs on certain subjects developed, *including one on psychiatric illness*. The course has been developed as a full module, professional development course, accredited by Bristol Polytechnic.

TITLE:	ENB Course 937:Behaviour Modification in Mental Handicap Nursing for Registered and Enrolled Nurses
COORDINATOR/S:	
BODY/IES:	Cumbria and Lancaster College of Nursing and Midwifery North Staffordshire College of Nursing and Midwifery Devonshire College of Nursing and Midwifery
SUMMARY:	
Length:	30 days, block, day-release basis or combination, over 30 wk period.
Aimed at	nurses working with challenging behaviour who wish to participate *as a member of a multi-disciplinary team* in formulating, developing, evaluating and modifying individual and group behavioural problems.
Admission requirements	relevant work with challenging behaviour
Award by	ENB Statement of Attendance
Content	Course will give each nurse an opportunity to practise, as a participant observer, a limited range of behaviour modification techniques and to take some initiative in developing behavioural programmes in association with a multi-disciplinary team.

TITLE: ENB Course 705:Behaviour Modification in Mental Handicap Nursing

COORDINATOR:

BODY: Bethlem Royal & Maudsley School of Nursing

*Hester Adrian Research Centre (HARC)

Devonshire College of Nursing & Midwifery

**Sister Dora College of Nursing & Midwifery

SUMMARY:

Length: 32-36 weeks

Form: not known

Aimed at: nurses wishing to improve their ability to *assess and formulate behavioural* programmes, either as an individual or as a member of a team.

Admission requirements: nurses on Parts 1 (RGN), 3 (RMN), 5 (RNMH) or 8 (RSCN) of the Professional Register, currently employed in the nursing of mentally handicapped individuals.

Award by Institution: ENB Certificate in Clinical Practice (and a recordable qualification on the UKCC Professional Register). Also recognised by CCETSW as PQS/79*.

Content: "to train a nurse to formulate and implement individual and group behavioural programmes, including the family and other care-givers where appropriate, in residential settings, including the treatment of mentally handicapped people within the context of a multi-disciplinary team".

NOTES: *Course in **Behavioural Approaches for Professionals working with People who have Learning Difficulties** (q.v., p. 105)

**Sister Dora College of Nursing & Midwifery is looking to seek accreditation by CCETSW in addition to the ENB

This course is pitched at developing higher level skills than the shorter **ENB Course 937**.

TITLE: ENB Course 939/993:Care of People with a Mental Handicap/Mental Illness in Community, Residential and Day Care Services.

BODY/IES

Avon College of Health

West Sussex College of Nurse Education

Francis Harrison College of Health Care

Romford College of Nursing, Midwifery and Health

Epsom & Kingston College of Nursing & Midwifery

County Durham College of Nursing & Midwifery

SUMMARY:

Length: 60 days

Form: two five-day modules and one seven-day module. Seven study days for project work. One feedback and evaluation day.

Aimed at: staff from multi-professional agencies who are currently working with people with a mental handicap/mental illness.

Admission requirements: Nurses on Parts 5 (RNMH) or 6 (ENMH) of Professional Register currently working with people with mental handicap. Suitably qualified professionals from education, social services or voluntary agencies.

Award: ENB Statement of Attendance,

Content: Three modules of study cover the broad headings of:
- values for living
- development of social policy and provisions
- the management of change

"Course members will be encouraged to develop the skills, knowledge and attitudes required in a service which sets out to empower the client through the creation of culturally valued life experiences in community settings."

NOTES: Avon College of Health have revised the course for 1993 when will be accredited as a full module by Bristol Polytechnic.

TITLE: ENB Course 807 Nursing People with a Mental Handicap/Learning Difficulty in the Community for Nurses on Part 5 (RNMH) of the Professional Register

COORDINATOR: Mrs P J Rout

BODY: Liverpool Polytechnic, School of Health Care

SUMMARY: The 807 course includes a behavioural skills-based unit, details of which are given below.

Length: 8 weeks

Form: Combination of workshops (four study days) and supervised practice/experiential learning (seven weeks)

Aimed at: post-registration RNMH nurses

Award: ENB Certificate in Clinical Practice

Content: Curriculum covers the theoretical principles of the behavioural approach; environmental factors and their influence on behaviour; rating scales and other assessment mechanisms; the application of functional analysis; understanding and use of a variety of methods for teaching and modifying behaviour; initiating and maintaining therapeutic skills with regard for ethical issues; accurate analysis of individual needs and setting measurable objectives.

Validation: ENB through Liverpool Polytechnic.

NOTES: At the time of the response the curriculum for the whole course was being reviewed in order to attain Diploma status and to attract validation through CNAA.

TITLE:	ENB Course 955 Short Course on the Care of the Violent or Potentially Violent Individual
COORDINATOR:	Not known
BODY/IES:	The Suffolk and Great Yarmouth College of Nursing and Midwifery County Durham College of Nursing and Midwifery Wakefield and Pontefract College of Health, Faculty of Nursing and Midwifery Ashworth Hospital Staff Edcuation Centre
SUMMARY:	
Length:	21 days
Form:	Combination of theory and elements of practice, supervised by course leader.
Aimed at:	post-registration RNMH nurses, open to social workers (CQSW) and unqualified staff, although the latter do not receive the Certificate of Attendance. (Wakefield & Pontefract, for professionals only, regardless of discipline)
Award:	ENB Statement of Attendance
Content:	The aims of the course are promote an 'increased awareness' of factors which provoke aggression and violence, and to develop 'appropriate skills in managing potential and actual violent behaviour'.
Validation:	ENB
NOTE:	The course is not specifically aimed at staff working with people with learning disabilities, but at staff who may have to respond to aggression/violence in any situation. The course is of general relevance.

TITLE: ENB Course 935 Advances in Mental Handicap Nursing for Nurses on Parts 2 (ENG), 4(ENM) or 6 (ENMH) of the Professional Register.

BODY: Epsom & Kinsgton College of Nursing & Midwifery

SUMMARY:
Length: 30 days

Form: 85% theory and 15% practice

Aimed at: Nurses, CQSW, other relevant qualifications.

Award: ENB Statement of Attendance

Content: Designed to deepen knowledge and understanding of mentally handicapped individuals and their needs and to study recent advances in care, education and treatment. Main emphasis placed on developing skill in planning, carrying out, and evaluating and modifying individual nursing programmes and assisting them to apply these skills in their own clinical setting.

TITLE: ENB Course 936 Developments in Mental Handicap Nursing for Nurses on Part 5 (RNMH) of the Professional Register

BODY: Epsom & Kingston College of Nursing & Midwifery

SUMMARY:

Length: 20/30 days

Form: 85% theory & 15% practice

Aimed at: Registered Nurses with two years post-registration experience of working with mentally handicapped people in hospital or in the community.

Award: ENB Statement of Attendance

Content: The course is intended to enable experienced nurses to study recent developments and trends in the nursing of mentally handicapped people in the family setting, the community and hospital.

Validation: ENB

TITLE:	ENB Course 770 Nursing in Controlled Environments for Nurses on Parts 3 (RMN) or 5 (RNMH) of the Professional Register
BODY:	Ashworth Hospital, Staff Education Centre
SUMMARY:	
Length:	Stage 1 - 22 days and Stage 2 - 12-16 weeks.
Form:	Includes clinical placements
Award:	ENB Certificate in Clinical Practice
Content:	The aims of the course are to provide an opportunity for first level nurses to participate in a structured and negotiated educational experience to enable them to be more effective as nurses in a multi-professional setting, in a secure environment
Validation:	ENB

TITLE:	ENB Course A12:Cognitive Behaviour Therapy
COORDINATOR/S:	
BODY/S:	No information
SUMMARY:	
Length	82 days, spread over 6 mth period.
Form	40 days theory and 42 days practice.
Aimed at	Nurses on Parts 3 (RMN) or 5 (RMNH) of the Professional Register
Admission requirements	a minimum of 12 months' experience in the community, current work in the community
Award by	ENB Certificate
Content:	details of curriculum not provided

TITLE: Diploma in Social Learning Theory and Practice

COORDINATOR: Dr Clive Hollin

BODY: University of Birmingham (School of Psychology)

SUMMARY

Length: 1 yr part-time, weekly day-release

Aimed at: practitioners who hold a post which permits the practice of cognitive-behavioural intervention with their particular client group.*

Admission: candidates must hold a relevant qualification (eg social work, nursing, teaching). Those with relevant experience and proven academic ability currently needing training will also be considered.

Award by Institution: Diploma in Social Learning Theory and Practice (incorporating ENB Certificate in Clinical Practice)

Content: principle objective to equip participants with sound knowledge of social learning theory and associated cognitive-behavioural techniques;
[1] Basic principles of learning:cognitive-behaviour therapy, theory and introduction to treatment
[2] Principles of learning cont'd:treatment skills and techniques; research skills
[3] Writing, conducting and monitoring complex cognitive-behavioural programmes for a range of client groups.

Client group models used will be dependent on membership requirements. Sessions will be included on working with *aggression*, sexual problems and family problems.

Validation: ENB Certificate (**AO2**) in post-qualifying studies and CCETSW (**PQS/68**) post-qualifying studies. Additionally the British Psychological Society have granted membership to those holding the Diploma.

NOTES: Initially the course was developed for child and adolescent client groups. The course has been broadened and is relevant to other client groups, including people with learning disabilities.

TITLE:	MA in the Applied Psychology of Mental Handicap (Specialist Management Programme)
COORDINATOR:	John Carpenter
BODY:	University of Kent at Canterbury (Centre for the Applied Psychology of Care)
SUMMARY	
Length	2 yrs, with flexibility to accommodate work commitments
Form	Combination of 16 twenty hour units taught in 10 one-week workshops with practical work in participants own agency. Course divided into units (each one-week workshop) which consists of three days theory and two days practical experience. Units offered by staff at Centre for the Applied Psychology of Social Care and The Canterbury Business School, with contributions from the Personal Social Services Research Unit.
Aimed at	"people leading the development of community-based services for people with mental handicaps [or mental health problems]" (separate MA offered by same dept.)
Admission requirements	a professional qualification *plus a senior position in a health, social services or voluntary organisation* which is engaged in the development of community care. Candidates normally expected to hold a first or second class degree together with a professional qualification in a relevant field. Access to a service willing to provide facilities for a work project also a requirement, usually the candidates place of work.
Award:	MA in the Applied Psychology of Mental Handicap
Content	Units offer mixture of management, service provision and behavioural skills. Includes an optional unit "Services for People with Challenging Behaviour".

SECTION 2 - SHORT COURSES/WORKSHOPS

Short courses and workshops have been identified which are provided by the following:

Chester & Wirral College of Nursing and Midwifery

Sefton School of Health Studies

Cheshire College of Health Care Studies

Sheffield and North Trent College of Nursing and Midwifery

Carshalton and Croydon College of Nursing and Midwifery

North London Joint College of Health Care Studies

Wealdon College of Health and Social Studies

Institute for Health Studies (Colchester)

Leeds College of Nursing and Midwifery

Anglia Polytechic/Faculty of Health & Social Work

E. Sussex & W. Kent Institute of Nursing and Midwifery

Mid and West Essex Dept of Nursing and Midwifery Education

Norfolk College of Nursing and Midwifery

Hertfordshire College of Health Care Studies

West Pennine College of Health Care Studies

Roding College of Health Care Studies, Claybury Hospital

West Yorks College of Health Studies

Wakefield & Pontefract College of Nursing & Midwifery

Southampton University College of Nursing and Midwifery (Tatchbury Mount Education Centre)

Ashworth Hospital, Staff Education Centre

Nottingham Health Authority, Department of In-service Education, Learning Disability services.

PROVIDER: Chester & Wirral College of Nursing & Midwifery

COURSE: Course of 3 half days covering:

Assessment and care planning
Accountability
Skills to manage challenging behaviour

PROVIDER: Sefton School of Health Studies

COURSES The College provides a course entitled "Mental Health Problems in People with Learning Disabilities" for nursing staff, social workers, psychologists and unqualified staff. It consists of 16 study days spread over a 2-3 month period. There is no supervised practice, but students are required to make up to six observational visits to relevant practice settings to supplement the study days. Unqualified staff attend only the first 5 day study block then present a mini-project on a half-day recall.

PROVIDER: Cheshire College of Health Care Studies

COURSE: 48 hours tuition, + 3 open learning modules + 8 week practical component on " Non Aversive Intervention in Challenging Behaviour"

PROVIDER: Sheffield and North Trent College of Nursing and Midwifery

COURSE: Post-registration workshops on "Gentle Teaching" (Hoots and Scott Goal Planning for Developmentally Disabled People system)

PROVIDER: Carshalton and Croydon College of Nursing and Midwifery.

COURSE: 3 courses on:

Understanding and responding to Challenging Behaviour (2 days)

Control and Restraint (1 week. Home Office approved)

Break-away techniques

PROVIDER: North London Joint College of Health Care Studies

COURSES: A number of short courses are to be provided in 1992/93 through the Continuing Education Dept. These include:

Behaviour Therapy (6 days)
Creating a Learning Environment (1 day)
Room Management Techniques (1 day)
Therapeutic Application of Social Learning Theory (1 day)
Process of Therapeutic Change (2 days)
Skills Building (1 day)
Special Needs and Sensory Impairment (6 days)

The Development Course for Health Care Assistants (7 days) includes work on methods of preventing aggressive or challenging behaviours.

Control and Restraint (5 days, Home Office approved)

Understanding and managing violence (2 days)

These courses are available to all grades of staff. Some have been developed as a direct result of needs analysis/discussion with service managers.

PROVIDER: Wealdon College of Health and Social Studies

COURSES: The following workshops related to challenging behaviour are provided:

Sexuality and people with learning disabilities (3 days)

Breakaway techniques 2 hours)

Control and restraint refresher course (2 hours)

Introduction to Gentle Teaching (1 day)

PROVIDER: Institute for Health Studies (Colchester)

COURSE: A new 14 session course was due to commence, covering theories of behavioural difficulties and a variety of responses. The course has been developed by psychologists, nurses and social workers.

PROVIDER: Leeds College of Nursing and Midwifery

COURSES: Coping with Violent Situations (1 day)

Coping with Challenging Behaviour (2 days)

Understanding and Responding to Difficult Behaviour (1 day workshop)

PROVIDER Bolton & Salford College of Midwifery & Nursing.

COURSE Violence & Aggression (3 days)

Violence & Aggression (2.5 days)

(Tutors trained by the Home Office)

PROVIDER: Anglia Polytechnic/Faculty of Health & Social Work

COURSE: Training is offered as part of in-service staff development programme within a health authority service for people with learning disabilities. This covers skills, knowledge and attitudes - in the workplace (but not supervised or assessed practice).

PROVIDER E. Sussex and W. Kent Institute of Nursing and Midwifery.

COURSE Two-day workshops for qualified nurses only, updating knowledge and principles.

PROVIDER Mid and West Essex Dept of Nursing and Midwifery Education.

COURSES Short courses open to qualified nurses, other professionals (paramedics, social workers, art therapists and teachers) and to unqualified staff.

PROVIDER Norfolk College of Nursing and Midwifery.

COURSES College-based short courses open to qualified nurses, other professionals (teachers (adult education), occupational therapists and speech therapists) and to nursing assistants.

PROVIDER	Hertfordshire College of Health Care Studies.
COURSES	Short courses provided on an 'In-service Training Basis'. Need for such courses is identified through joint education and service meetings. From these meetings the precise nature of the courses, their target student group and the balance of college and practice-based learning is decided. Courses are therefore tailor-made to meet service needs.
PROVIDER	West Pennine College of Health Care Studies.
COURSES	Provides a 2 day course including theory and experiential learning for nurses, other professional and unqualified staff.
PROVIDER	Roding College of Health Care Studies, Claybury Hospital
COURSES	Runs a one day workshop on demand, which is open to any interested staff, regardless of qualification. Service managers usually nominate staff, and organise follow-up practice supervision.
PROVIDER	Wakefield and Pontefract College of Nursing and Midwifery.
COURSES	2 day course on 'Staff Awareness towards Violence and Aggression', which is run every month and is open to all disciplines, qualified and unqualified. The course includes one day on understanding aggression, escalation and reduction and one day on Control & Restraint, Self-defence and breakaway techniques. This includes theoretical and practical training. This is not restricted to staff working with people with learning disabilities.

PROVIDER West Yorks College of Health Studies.

COURSES The College is involved in two courses:

i) a 1 day workshop in 'Supporting People with Challenging Behaviours', organised by service personnel (usually community nurses and psychologists) and targeted at residential and day care staff (open to all grades and qualifications of staff with experience of working with people with learning disabilities

ii) a 13/14 day course spread over 10/12 months, specifically geared to working with people who exhibit challenging behaviour. The course is organised for small groups of staff who work with a particular client, and are required to put into practice what they have learnt from the study days.

PROVIDER Southampton University College of Nursing and Midwifery (Tatchbury Mount Education Centre)

COURSES Workshops primarily for unqualified staff covering functional analysis, skills training. They have tried to develop supervised practice development for qualified staff but have had difficulty in finding practice supervisors with sufficient expertise in this field.

PROVIDER Ashworth Hospital, Staff Education Centre.

COURSES The Centre runs a number of courses on a continuing education basis.

i) A monthly course on mental health nursing appreciation for RNMH qualified nurses;

ii) Workshops related to very specific clients needs - such as the management of people with learning disabilities who exhibit self-injurious behaviour. These workshops are also made available to other NHS service providers.

PROVIDER

Nottingham HA, Dept. of In-service Education, Services for People with Learning Disabilities.

COURSES

The Department offers a number of short courses/workshops relevant to this specific area of work, which are open to all grades and qualifications of staff, and which are marketed to other statutory and independent sector agencies in the locality. The courses are:

i) Understanding and managing aggression (3 days)

ii) Assertiveness (2 days)

iii) Introduction to Counselling (2 days)

iv) Autism (1 day)

v) Psychiatric Disorders and Learning Disability (2 days)

In addition, the Dept. offers more general courses on care planning, legal and professional accountability, assessment, sexuality and adult sexual abuse.

SECTION 3 - PLANNED COURSES

The following Colleges reported that they were in the process of planning courses in this area.

Avon College of Health

Bolton and Salford College of Nursing and Midwifery

Mid Trent College of Nursing and Midwifery

Lancashire College of Nursing

Dorset and Salisbury College of Nursing and Midwifery

Bede College of Nursing and Midwifery, Sunderland

Thames College of Health Care Studies

Anglia Polytechnic/Faculty of Health and Social Work

Birmingham College of Nurses Education

Isle of Man Centre for Nurse Education

Ashworth Hospital Staff Education Centre

Chester & Wirral College of Nursing and Midwifery

The Suffolk and Great Yarmouth College of Nursing and Midwifery

St Martin's College, Lancaster

East Sussex and W Kent Institute of Nursing and Midwifery

Mid & West Essex Dept of Nursing and Midwifery Education

Southampton University College of Nursing & Midwifery

Wealdon College of Health and Social Studies

Rampton Staff Education Centre

Hertfordshire College of Health Care Studies

Norfolk College of Nursing and Midwifery

North London Joint College of Health Studies, North Middlesex Hospital

Francis Harrison College of Health Care

Mental Impairment Evaluation and Treatment Services Unit, The Bethlem Royal Hospital South East Thames RHA

PROVIDER: Avon College of Health

COURSES: The following courses will be accredited by Bristol Polytechnic and will be accorded CATS points. It is anticipated that it will be possible to link both into the ENB Higher Award Framework.

i) Mental illness in People with Learning Disabilities Half-module course, to start in 1993. The aims are:

- to increase understanding of the range of mental illnesses which people with learning disabilities might experience;
- to develop skills in recognising and assessing mental illness in this client group;
- to enable the student to demonstrate psychiatric nursing skills in relation to the care of one individual.

ii) Professional Development: Caring for People with Learning and Physical/Sensory Disabilities Full module course, to start in 1993. The aims are:

- to critically examine multi-disciplinary approaches to the management of care for clients with both learning disabilities and physical/sensory disabilities;
- to enable the student to deliver high quality care within a multidisciplinary team to these clients;
- to promote the application of the theory gained to practice.

PROVIDER: Bolton & Salford College of Nursing & Midwifery

COURSE: Diploma and pathway to degree level studies within this field of practice are to be developed in the next two to three years. It is anticipated that the course will be validated by the ENB and University of Salford. The course will be offered through the ENB Framework and Higher Award.

PROVIDER: Mid Trent College of Nursing and Midwifery Education.

COURSES: Early stages of planning courses which are intended to be of interest to post-registration nurses, social workers and unqualified staff. There is a strong possibility that the NCVQ would provide the model for courses assessment, and courses may also be linked in with the ENB Framework for Higher Awards.

PROVIDER: Lancashire College of Nursing

COURSES

i) Early planning stages of a courses on the lines of PBCNS 770, "Nursing within Controlled Environments. Two/three years to first intake;

ii) Short course on understanding why people exhibit violent or aggressive behaviour, and approaches to helping them. This course is still in the planning stage, but is intended to last for 10 days, to be open to all staff and to be multi-agency. The course will include understanding of how staff actions and the environment may influence behaviour, and how incidents of challenging behaviour can be constructively managed. An emphasis on social role valorisation and people's rights will run throughout the course.

PROVIDER: Dorset & Salisbury College of Midwifery & Nursing.

COURSES: Courses are to be developed after internal re-structuring is completed. This training will be open to qualified nurses, other professionals and unqualified staff. The training may be validated.

PROVIDER: Bede College of Nursing & Midwifery, Sunderland.

COURSES: Plans were in the early stage of development to introduce the ENB validated course 937 (Behaviour Modification in Mental Handicap Nursing) in the financial year 1992/93. At the time of response it was anticipated that the course would be open to qualified nurses only.

PROVIDER: Thames College of Health Care Studies.

COURSES: A course is to be developed in the second half of 1992 for introduction in 1993. It is probable that this training will be open to teachers and social workers, and possibly also to unqualified staff. It is anticipated the course will be validated by the University of Greenwich and the ENB.

PROVIDER: Anglia Polytechnic - Faculty of Health and Social Work, Post-registration Davison, Advanced Practice Section - Mental Health and Learning Disability Nursing.

COURSES: Work has begun on a course scheme for the ENB Higher Award and B Sc (Hons). It i probable that this course will be open t other professionals and unqualified staf but details of prerequisite qualifications and experience were still under discussion.

PROVIDER: Birmingham College of Nurse Education.

COURSES: A College-based course is under development for intake in the latter part of 1992. The course will be open to social workers and unqualified staff and will be validated, but no further details were given.

PROVIDER: Isle of Man Centre for Nurse Education.

COURSES: The Centre is in the process of developing a continuing education department, and intends to conduct a training needs analysis within health and social service departments caring for people with learning disabilities. It is expected that courses in this specific field will be developed in the future, but no details were available.

PROVIDER: Ashworth Hospital Staff Education Centre, Merseyside.

COURSES: A course is to be developed over the next year, which will be open to other professionals and unqualified staff, based on open learning and action learning assessments The course is to be validated through the ENB and higher education.

PROVIDER: Chester & Wirral College of Nursing & Midwifery

COURSE: The timetable for this developing is over the next 12 months. It is anticipated that the course will be open to staff with other professional qualifications but not to unqualified staff, and be validated by the ENB. No further details were made available.

PROVIDER: The Suffolk and Great Yarmouth College of Nursing & Midwifery

COURSE: New training was under discussion but no definite planning cycle had been agreed. It was anticipated that the training would be open to other professional qualifications (possibly social workers and other community care qualifications) and to unqualified staff. The training would include both college and practice-based learning, but the details had not been decided. It was anticipated that some training would be validated.

PROVIDER: St. Martin's College, Lancaster

COURSE: Their present training included RNMH and RMN degree level training, and this area is to be expanded - probably for introduction in 1993. The new training would probably be open to DSW qualified staff, and possibly unqualified staff but the latter would need 'experience'. The balance between college and practice-based learning was still to be decided. It was anticipated that the new training would be validated by the ENB within the Framework for the Higher Award.

PROVIDER: East Sussex & W. Kent Institute of Nursing & Midwifery

COURSE: The timetable for this development is over the next 6-8 months. It is anticipated that the course will be open only to qualified nursing staff. The balance between theory and practice might be 25% to 75%, but the details had not been finalised. It was anticipated that the course would be validated by the ENB. No further details were made available.

PROVIDER: Mid & West Essex Dept. of Nursing & Midwifery Education.

COURSE: This new training is to be developed from part of and indication programme followed by on-going practice-based sessions. It will be open to all members of the multi-disciplinary team, including unqualified staff. It was anticipated that this training would be validated in the near future, but no further details were given.

PROVIDER: East Sussex & W. Kent Institute of Nursing & Midwifery

COURSE: The timetable for this development is over the next 6-8 months. It is anticipated that the course will be open only to qualified nursing staff. The balance between theory and practice might be 25% to 75%, but the details had not been finalised. It was anticipated that the course would be validated by the ENB. No further details were made available.

PROVIDER: Southamptom University College of Nursing & Midwifery

COURSE: There were plans to develop training for staff working with this client group on a consultancy basis working with individual staff teams and clients. This training would therefore be open to all staff, regardless of qualification, working in those specific teams. There were no plans at the time to develop formal courses although it was felt that this was a real need for the future. The consultancy training would not be externally validated.

PROVIDER: Wealdon College of Health and Social Studies

COURSE: The College was working on curriculum development for a modular courses entitled 'Challenging Behaviour', at level II for implementation in January 1993. This would be open to staff who were able be assessed at level II, regardless of particular qualification; staff who were not eligible for assessment at this level would simply receive a Certificate of Attendance. It was anticipated that the course would be 50% college -based and 50% practice based. The course may be validated by Surrey University/ENB, CNAA/ENB or BTEC/ENB

PROVIDER: Rampton Staff Education Centre.

COURSE: The Centre was planning a number of courses to be implemented in about 1 year. These would be open to nurses, other professionals and unqualified staff from within the institution and outside authorities. The balance of college and practice-based learning would depend on the level of particular course, and practice supervision would be carried out be qualified tutors, training mentors and supervisors/assessors. It is anticipated that Sheffield Polytechnic will be involved in validating this training.

PROVIDER: Hertfordshire College of Health Care Studies

COURSES: Two courses were undergoing development and were to be submitted for ENB validation, with a view to starting the courses in October 1992.

i) Care of People with a mental handicap who present challenging behaviour(s) The course will be of 22 days duration, to be completed over a period of 3 months. 18 days were study-oriented, with 2 placement days, and a briefing and review day. The curriculum was developed around 5 themes, which were:

Values & Attitudes
Aspects of Care
Communication
Legal & Professional
Nature

ii) Contemporary Approaches to the Care/Management of People with Learning Disabilities who Present with Mental Health Problems This course is planned to last 30 days over a 22 week period, based primarily around study blocks and days with some visits incorporated. The specific themes of this course are:

Assessment & Diagnosis
The environment
Therapeutic Interventions
Legal and Professional Issues

Both courses focussed on the interaction between the individual themes, and on the integration of theory and practice. Reflective diaries, learning contracts and action learning are employed to promote these aims.

Both courses are also open to qualified nursing staff, other professionals and unqualified staff, providing they meet the course entry requirements. Entry to the course may depend on current role, previous experience etc.

PROVIDER: Norfolk College of Nursing & Midwifery

COURSE: There were plans to develop a one week course, with a follow-up after a period of practice. This course would be open to all qualified staff, and in due course might be extended to included unqualified staff. There will be a 3-day workshop, followed by a period of practice in the work place, with access to courses tutors for support and guidance. A two-day review would be held approximately 2 months later. A practical assignment would probably be included in the course. In due course it was anticipated that such a course would be offered as part of the ENB's Higher Award scheme. The College was considering the possibility of creating a full ENB post basic course on Challenging Behaviour.

PROVIDER: North London Joint College of Health Studies, North Middlesex Hospital

COURSE: There were plans to develop the following courses:

i) a 6 day course to be available in early 1993, which would be open to nurses, CSS, CQSW, and qualified supervisory staff in the voluntary sector.

ii) the introduction of the ENB 939/993 course, (in conjunction with the mental health training section) It was anticipated that this would be validated by the ENB in August 1992. The core themes for this course were:

- Health Studies
- Psychological Studies
- Socio-political Context of Care
- Management of Care
- Ethics
- Research
- Nursing Theory & Practice.

The course comprises 20 days of theory and visits over a period of 12 weeks, plus one day each for briefing and review.

A feasibility study for developing the ENB 937 course (Behaviour Modification in Mental Handicap Nursing) was to commence in late 1992

PROVIDER: Epsom and Kingston College of Nursing & Midwifery

COURSE: The College is developing an MSc in Mental Health/Mental Handicap Nursing for implementation in the academic year 1992/93. These courses will be open to registered nurses and qualified social workers (CQSW); unqualified staff will be eligible provided that they can prove capable of studying at Masters level. The course will be modular in form, and will be validated by South Bank University. No further details were provided.

PROVIDER: Francis Harrison College of Nursing & Midwifery

COURSE: The College was in the process of developing an ENB course intended for nurses, social workers, psychologists and health care assistants. This would be a modular course involving 10 college days over 6 months and would be offered at CATS level 2 and level 3. The course would also be validated by the University of Surrey.

PROVIDER: Bedford School of Nursing

COURSE: Plans to develop a course on challenging behaviour as part of modular degree programme in Health Care which is to commence in October 1992. The challenging behaviour module will offered in the second year. The course will be open to people with health and social work related qualifications, but not to unqualified staff. The course will be validated through CNAA.

PROVIDER:

Mental Impairment Evaluation and Treatment Services Unit, The Bethlem Royal Hospital
South East Thames RHA

COURSE:

Two courses on Learning Disability and Challenging Behaviour were being developed. These were a short course - approx 3 wks full-time with 2 wks 'day release' to give people necessary skills in assessment and intervention with challenging behaviour with close on-site supervision, and a longer course leading to a diploma - approx 3 mths full-time, 9 mths 'day release' - to give people the same skills but with minimal supervision.

Both courses will be intended to give grounding in theoretical and practical issues against a background of normalisation. The course will not be exclusively concerned with behavioural perspective, for example the influence of psychiatric illness, autism and legal issues will be incorporated.

Aimed at direct care staff as well as professionals who will be able to directly apply their knowledge at their place of work. Course flexibility is intended to accommodate work demands of participants.

The course results from the realisation amongst the learning disabilities section of the Institute of Psychiatry that there is little available help for people with challenging behaviour.

PROVIDER: The Loddon School/ The Loddon Institute for Advancement in Specialist Education (Basingstoke). Contact: Mrs M Cornick, Principal and Education Director.

COURSE: Training is developed from the course Strategies for Crisis Intervention and Prevention, provided and marketed by the New York State Office of Mental Retardation and Developmental Disabilities.

This specific training is provided for all staff (qualified and unqualified) working at the school and is offered to other agencies. The aims of the training are "the management of aggressive, violent and self-injurious behaviours by human interaction to give assistance in the least restrictive manner to help the client control his/her behaviour" (course description). The package includes the following elements:

a) an awareness of the problem;
b) identification and understanding of people with learning disabilities;
c) the use of calming techniques;
d) specific interventions;
e) basic concepts and guidelines for preventing disruptive behaviour.

In addition, all staff receive training on other aspects of the care and its underlying philosophy. The areas of training offered include:the course is as follows.

a) communication, Makaton and PICS
b) massage and relaxation
c) sensory development
d) the national curriculum
e) quality and coordination of training
f) record keeping
g) curriculum development
h) child care and lifestyle
i) music
j) relaxation

The school has developed the concept that, for its particular client group, it should provide an environment in which the level of stress for children would be reduced by reducing the number of transitions that occur in a day. This philosophy has had led to the development of a daily process called "the Loddon Day", about which staff also receive training.

PROVIDER Castle Priory College, Oxfordshire (maintained by the Spastics Society)

COURSES: The College provided a wide range of short courses and workshops in the winter/spring of 1991/92. Of specific reference to this client group were the following three courses:

a) Autism and those with autistic traits - coping with challenging behaviour (2 day workshop)

b) Behavioural principles and programme planning (3 day workshop)

c) Challenging behaviour in the classroom (1 day workshop)

PROVIDER M.H.N.A (Mental Handicap Nurses' Association) Training Unit.

COURSES: Included amongst their courses for 1992 were the following:

a) a 3 day residential workshop entitled Constructive Work with People who Challenge. This course was designed for staff with some experience and expertise in this field, particularly those with responsibility for planning programmes and for supporting others in carrying out supervisory work.

b) a two day workshop called An Introduction to Challenging Behaviour, intended for inexperienced staff

PROVIDER The A.P.T. (Association for Psychological Therapies)

COURSES: The A.P.T. provided an extended training course in Behaviour Modification Techniques

SECTION 4 - AGENCIES OTHER THAN COLLEGES OF HEALTH/NURSING

The following agencies were also identified which provide courses for staff working with this client group.

Worker's Educational Association, Western District.

The Loddon Institute for Advancement in Specialist Education (The Loddon School, Basingstoke).

Castle Priory College, Oxfordshire (maintained by the Spastics Society)

M.H.N.A (Mental Handicap Nurses' Association) Training Unit.

PROVIDER:	Workers Educational Association (Western District). Contact: Mandy Neville
COURSE:	Developing Skills and Strategies in Relation to Challenging Behaviour

This course is no longer directly provided by the WEA, as the original three-year funding the Rowntree Trust has come to an end and no further sponsor has come forward. Funding was provided to enable the course coordinator to convert the course into a training pack which could be purchased by other trainers or training agencies to actually provide. The form and content of the Course is as follows.

SUMMARY:

Length:	40 day course, two days a week.
Form	modular programme of theoretical considerations complemented by work assignments at home and place of work, and visits to other establishments.
Aimed at	"staff and carers who are involved either professionally, voluntarily or through family ties, with people who have learning difficulties and challenging behaviour." No academic qualifications necessary
Award	Certificate of completion
Content	[A] Individual Growth and Development: looks at wide variety of factors which can affect individual needs [B] Designing Services for Individuals:section on traditional, current and alternative approaches in designing interventions [C] Effective Communication:introduces wide range of skills and approaches to create a positive environment.
Validation	When directly provided the course was validated by Bristol Polytechnic offering CATS points at level 3.
NOTES:	Mental illness features as part of Module [A].

Issues arising

A number of issues emerged from the material which Colleges sent either in the questionnaire or in course details which some respondents also included. Although this information is provided in the Sections of the Directory proper, the following points have been brought together here for the sake of clarity and focus.

a) a number of courses were described as 'tailor-made', particularly short courses and workshops. One College was planning to develop training to be offered on a consultancy basis, which would meet identified training needs of individual staff working with individual clients in particular settings. The Ashworth staff education centre also provided training to meet specific staff and client needs - and offered training to assist staff working with very specific behaviours, such as head-banging. This training was geared to meeting individual staff and client needs;

b) In addition, three externally validated courses were described as having been developed in response to service demands, or in conjunction with service managers and planners. As it happens, all these specifically addressed the issue of mental illness in people with learning disabilities;

c) Some training providers were finding it difficult to identify practice supervisors who were as or more skilled than the students they were supposed to be helping to develop;

d) a number of Colleges (6) were seeking to develop their courses within the ENB Framework for the Higher Award, of which 3 were seeking validation for courses in terms of CATS points.

e) courses which explicitly addressed the issues of mental illness within learning disabilities were few, at least in so far as the material which was provided indicates. Only 6 of the total on which extensive information was provided made specific reference to this particular combination of client needs. Whilst it may be that other respondents simply did not provide this information, it does fit with some of the material reported in earlier chapters to the effect that the identification of mental illness in people with learning disabilities is not as well developed here as in the US (Chapter 4), and that this is a desired but not always available skill on the part of staff working with this client group (Chapter 6).

The themes of meeting individual staff and client needs therefore emerges from this material, as does the perceived need for training to meet the needs of people with learning disabilities and mental health problems. The strong link between training and service providers in some areas at least, was apparent.

SECTION IV

Taking the Initiative

CHAPTER 8

CONCLUSIONS AND RECOMMENDATIONS

Summary of Main Conclusions

A wide variety of comments and observations were made in interview and on the postal questionnaires which have been reported in Section Two, Perceptions of Providers and Purchasers. Whilst these findings should be treated with some caution given that the response rates from both surveys were not as high as might have been hoped, a number of tentative conclusions can be drawn. These are strengthened in some cases by the supporting evidence from the literature review. The overall picture is one of diversity and variety - of:

a) definitions of challenging behaviour - which tend to be general and focused on the consequences of behaviour for service providers, carers and 'the community';
b) models of service provision - including the use primarily of both specialist support teams and residential services (short and long-stay);
c) sources and types of training used by service managers - Colleges of Nursing and Midwifery/Health Studies, external providers such as the BILD, MHNA and APT, Departments of In-service Education and specialist staff/consultants;
d) skills sought from staff - indicating a variety of therapeutic approaches to meeting the needs of the client group.

From the data it is possible to suggest five main conclusions:

1. there is evidence of a continuing role for the NHS as a direct provider of services for this client group. In addition, the clinical skills of specialist nurses are valued by both purchasers and providers. This indicates a commitment from both purchasers and providers to the

continuing role of a specialist nurse in this area - this is not surprising given the nature of the respondents but, nonetheless, reassuring for nurses in learning disabilities that some managers, in particular, recognise their contribution;

2. the importance of connections between challenging behaviour and mental illness are recognised and a shortage of specific training in this area has been identified by some purchasers and providers. Some training providers are in the process of developing courses to meet this need;
3. the value and advantages of joint/shared training are widely recognised but there is confusion over exactly what this means and some anxiety over the implications for professional identity;
4. training courses in challenging behaviour are developing explicitly in response to local service needs, although it is not clear whether the career implications for individual nurses of any particular programme are necessarily informing course development; and
5. a variety of models are being drawn upon to construct training programmes that, with the growth of locally-focussed courses, emphasise the importance of identifying national standards to ensure comparability between courses and localities. Some Colleges of Nursing and Midwifery/Health Studies are working to develop their post-registration courses in terms of the Framework for the Higher Award and may also be developing courses which will attract CATS points under the CNAA system.

These specific conclusions are all part of a situation where those responsible for training programmes, their purchase, acquisition and delivery, are under tremendous pressures. In challenging behaviour the expectation is that nurses can deliver - the problem for nurse educators is that at times they have been overtaken by events and it is not clear to some of those on the ground what precisely it is that they have to deliver and where they will find the time to develop appropriate programmes. Such a comment is not surprising but, nonetheless, it has to inform any recommendations that we make.

Recommendations

The general area of challenging behaviour is one that is especially topical at the moment. Publication of the Ashworth Inquiry (DH, 1992b) has highlighted the role of the special hospitals that has evoked comment and concern outside of the professional arena. Under a far less intense spotlight the Reed Committee (DH, 1992a) is considering, as part of its brief on mental illness, issues relating to challenging behaviour and some of its reports are already in the public domain. Early in 1993 the Department of Health will publish the report of the Mansell Committee on challenging behaviour in learning disabilities.

In such a context the recommendations that are forwarded for consideration are made on the assumption that the ENB could, and should, have a prominent role to play in the general debate that will be generated in this area. It is very much a case of being seen to take the initiative rather than responding to events and issues that others are credited with identifying and defining. This has a special urgency as nurse education has to tackle issues of working ever closer with higher education, grappling with CATS and associated issues, recognising the importance of outcomes in terms of NVQ competences, and ensuring the maintenance of quality. The recommendations fall under a number of headings: support, guidance, and clarification.

1. Support Since the Board took over from the GNC in 1983 nurses in learning disabilities, along with mental health, have

held an annual conference at Ripon. With organization of the conference being sub-contracted for the first time this year there is the opportunity to build upon the Ripon tradition and use this to provide a more broadly-based resource group that could act as an exchange of developments within learning disabilities in general and challenging behaviour in particular. Such a 'National Resource Group' could have a broader membership than nurse educators and increase the momentum of recent years to involve managers along with users. An annual report has been produced over recent years and this could be developed as part of a broader publication programme, e.g. newsletters and the like. It could, for example, provide a forum through which to discuss this report if this was felt appropriate.

Ripon is an established event and it provides a readily available pivot around which networks and initiatives could be developed.

2. Guidance There is considerable diversity in the way that educators organise their programmes. Such diversity can be well-reflected in the Framework for the Higher Award. However, as a framework welcomed because of the flexibility it offers there is the difficulty some find in learning how to best use that flexibility. Here, implementation rates of a specific and focussed type would help those to whom the terms are difficult to appreciate in concrete situations. In particular, issues relating to challenging behaviour could be identified for three of the ten characteristics:

Characteristic 2 - specialist skills
Characteristic 5 - flexible and innovative approaches
Characteristic 7 - role model.

3. Clarification There is a pressing need for clarity over the use of terms:

a) the distinction between joint and shared training and the concept of shared learning;

b) what is meant by challenging behaviour;

c) how mental illness relates to challenging behaviour;

d) what is meant by linking learning disabilities, challenging behaviour and mental illness.

Until there is common usage the issues raised by considering these terms will fail to be resolved.

The Board could make a prominent contribution in taking the lead over such matters.

APPENDIX A

Postal Questionnaires

UNIVERSITY OF YORK
Department of Social Policy & Social Work

No. ......

WORKING WITH PEOPLE WITH LEARNING DISABILITIES AND ASSOCIATED MENTAL ILLNESS WHO EXHIBIT CHALLENGING BEHAVIOUR.

1 Courses presently on offer

Do you at present provide any training (whether as part of broader courses or specifically on this subject) for professionally qualified staff who work with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness? (Please delete as appropriate)

YES/NO If **YES**, please go to question 1.1
If **NO**, please go to question 2.

2 Are these courses open to staff with professional qualifications other than nursing and if so, which qualifications?

2.1 Are they open to staff with no professional qualifications?

2.2 How are these courses organised - what is the balance between college and practice-based learning? What are the arrangements for practice supervision?

2.3 Are these courses validated by an external body? (Please delete as appropriate).

YES/NO If **YES**, please state which body/ies validate this training?

It would be particularly helpful if course syllabuses and any other details could be made available.

/cont.

3 Planned courses

Do you have any definite plans to provide any training (whether as part of broader courses or specifically on this subject) for professionally qualified staff who work with people with learning disabilities who exhibit challenging behaviour and may have an associated mental illness? (Please delete as appropriate)

YES/NO If **YES**, please go to question 2.1
If **NO**, please go to question 3.

3.1 What is the timetable for developing and introducing this training?

3.2 Will these courses be open to staff with professional qualifications other than nursing and if so, which qualifications?

3.3 Will they be open to staff with no professional qualifications?

3.4 How will these courses be organised - what will be the balance between college and practice-based learning? What will be the arrangements for practice supervision?

3.5 Do you anticipate that these courses will be validated by an external body? (Please delete as appropriate)

YES/NO If **YES**, please state which body/ies will be asked to validate this training?

It would be particularly helpful if course syllabuses and any other details could be made available.

/cont.

4 Joint and shared training

4.1 What do you think are the relative advantages and disadvantages of joint training for staff working with this client group?

4.2 What do you think are the relative advantages and disadvantages of shared training for staff working with this client group?

5 Standards

5.1 How do you think that standards of competence on the part of course participants should be determined, and by whom?

5.2 How do you think that standards of course comparability between different providers of education and training should be determined, and by whom?

/cont.

6 Definitions

We appreciate that the term "challenging behaviour" is broad and can be used to refer to a range of types of difficulty, from serious offending to behaviour which may limit the acceptability of individuals in ordinary community life. Please describe how **you** define challenging behaviour in relation to the training which you offer to staff working with this client group.

7 Skills required

7.1 What distinctive and specific skills do you consider that qualified nursing staff working to meet this particular combination of client needs ought to have? How do you think these skills should be developed from pre-registration training?

7.2 What distinctive and specific skills do you consider that staff with other professional qualifications working to meet this particular combination of client needs ought to have? How do you think these skills should be developed from pre-qualification training?

7.3 What distinctive and specific skills do you consider that staff without professional qualifications working to meet this particular combination of client needs ought to have? How do you think these skills should be developed?

THANK YOU FOR YOUR ASSISTANCE

/cont.

UNIVERSITY OF YORK
Department of Social Policy & Social Work

WORKING WITH PEOPLE WITH LEARNING DISABILITIES AND ASSOCIATED MENTAL ILLNESS WHO EXHIBIT CHALLENGING BEHAVIOUR.

1 Definitions

We appreciate that the term "challenging behaviour" is broad and can be used to refer to a range of difficulties, from serious offending to behaviour which may limit the acceptability of individuals in ordinary community life. Please describe how **you** define challenging behaviour in relation to the services which you offer to this client group.

2 Current provision

Do you at present provide any specialist services for people with learning disabilities who may have an associated mental illness and who exhibit challenging behaviour? (Please delete as appropriate)

YES/NO	If **YES**, please go to question 2.1 If **NO**, please go to question 3

2.1 Service models Please describe the type of services you offer for this client group (For example, specialist residential or day care services, specialist domiciliary support services, specialist assessment). If you can easily report the number of places available or size and composition of staff teams this would be additionally helpful but is not so important.

/cont.

3 Future provision

Do you have any definite plans to provide any specialist services for people with learning disabilities who may have an associated mental illness and who exhibit challenging behaviour? (Please delete as appropriate)

YES/NO	If **YES**, please go to question 3.1. If **NO**, please go to question 4.

3.1 Service models Please describe the type of services you plan to offer for this client group (For example, specialist residential or day care services, specialist domiciliary support services, specialist assessment). If you can easily report the number of places to be provided or the size and composition of staff teams this would be additionally helpful but is not so important.

4 Service reductions

Do you have any definite plans to withdraw from the direct provision of specialist services for people with learning disabilities who may have an associated mental illness and who exhibit challenging behaviour? (Please delete as appropriate)

YES/NO	If **YES**, please go to question 4.1 If **NO**, please go to question 5.

4.1 Is this withdrawal from services the result of reduction in need or is it anticipated that other agencies will provide services for this specific client group?

If other agencies will be providing such services are they likely to be (please circle as necessary):

Other health service providers
Local authority social services
Private sector agencies
Voluntary sector agencies
Combination of the above
(please specify)

Decision not yet taken

/cont.

5 Sources of training - qualified nursing staff

IF YOU ARE CURRENTLY PROVIDING OR ARE PLANNING TO PROVIDE any specialist services for this client group, please indicate the source(s) of training which is available/may be available for **qualified nursing staff** (Please circle as many as appropriate):

Own training department
College of Health
Other external providers (eg BIMH, WEA)
Other (please specify)

Not yet decided

5.1 Please describe the types of courses your staff attend/may attend (eg. ENB courses, courses validated by other bodies, non-validated courses).

5.2 Please give any general views you may have about the relative merits of the different types of courses and providers which your staff attend/may attend.

5.3 Please give any general views you may have about the advantages and disadvantages of joint and shared training for staff working with this client group.

/cont.

6 Sources of training - staff with other professional qualifications

IF YOU ARE CURRENTLY PROVIDING OR ARE PLANNING TO PROVIDE any specialist services for this client group, please indicate the source(s) of training which is available/may be available for staff with other professional qualifications: (Please circle as appropriate)

Own training department

College of Health

Other external providers (eg BIMH, WEA)

Other (please specify)

Not yet decided

6.1 Please describe the types of courses your staff attend/may attend (eg. ENB courses, courses validated by other bodies, non-validated courses).

6.2 Please give any general views you may have about the relative merits of the different types of courses and providers which your staff attend.

6.3 Please give any general views you may have about the advantages and disadvantages of joint and shared training for staff working with this client group.

/cont.

7 **Sources of training - unqualified staff**

IF YOU ARE CURRENTLY PROVIDING OR ARE PLANNING TO PROVIDE any specialist services for this client group, please indicate the source(s) of training which is available/may be available for staff with no professional qualifications: (Please circle as appropriate)

Own training department

College of Health

Other external providers (eg BIMH, WEA)

Other (please specify)

Not yet decided

7.1 Please describe the types of courses which your staff attend/may attend (eg. ENB courses, courses validated by other bodies, non-validated courses).

7.2 Please give any general views you may have about the relative merits of the different types of courses and providers which your staff attend/may attend.

7.3 Please give any general views you may have about the advantages and disadvantages of joint and shared training for staff working with this client group.

8 **Skills required**

8.1 What distinctive and specific skills do you consider that qualified nursing staff working to meet this particular combination of client needs ought to have? How do you think these skills should be developed from pre-registration training?

8.2 What distinctive and specific skills do you consider that staff with other professional qualifications working to meet this particular combination of client needs ought to have? How do you think these skills should be developed from pre-qualification training?

8.3 What distinctive and specific skills do you consider that staff without professional qualifications working to meet this particular combination of client needs ought to have? How do you think these skills should be developed?

/cont.

9 Standards

9.1 How do you think that standards of competence on the part of course participants should be determined, and by whom?

9.2 How do you think that standards of course comparability between different providers of education and training should be determined, and by whom?

THANK YOU FOR YOUR ASSISTANCE

APPENDIX B

LIST OF STEERING GROUP MEMBERS AND RESEARCH TEAM

Steering Group

Mr C Allison, ENB Board Member, Chairman of Mental Handicap Nursing Committee

Ms J Clarke, ENB, Research and Development Assistant, (Phase 3 only)

Mr F Holden, ENB, Assistant Director, Research, Development and Continuing Education, (Phases 1 and 2 only)

Mrs J Smith, ENB, Education Officer - Mental Handicap Nursing, Chester Office

Mr P Tuddenham, ENB Co-opted Committee Member, Vice Chairman of Mental Handicap Nursing Committee

Research Team

Mr J Brown, Director

Ms M Clifton, Research Fellow

Ms V Naylor, Research Fellow (until February 1992)

Mrs B Kindness, Project Secretary

BIBLIOGRAPHY

Allen D., Banks R., Staite S. (Eds), (1991), *Meeting the Challenge*, Some UK perspectives on community services for people with learning difficulties and challenging behaviour, London, KFC

Bailey, J. S. and Pyles, D. A. M. (1989), 'Behavioural Diagnostics', in Cipani, E. op cit, pp. 19-36.

Ballinger B. R. and Reid A. H., (1971), 'Psychiatric disorder in an adult training centre and a hospital for the mentally handicapped', *Psychological Medicine*, 7 pp. 525-528, quoted in Holland and Murphy, (1990), op. cit.

Blunden R., Allen D. (Eds), (1987), *Facing the Challenge: an ordinary life for people with learning difficulties and challenging behaviour*, King's Fund Project Paper no. 74, London, KFC,

Brandon D., (1990), 'Gentle Teaching', *Nursing Times*, , 86, 2, 62-63

BIMH (1991), Seminar Paper 1, *Service Responses to People with Learning Difficulties and Challenging Behaviour*, BIMH, page 1

Bridgen P., and Todd, M., (1990), 'Challenging Behaviour', *Mental Handicap*, 18, pp. 99-104, quoted in BIMH, (1991), p. 3

Brown J. (1991), 'The residential setting - a policy overview' in Thompson T. and Mathias P. (eds), *Preparing for Practice*, Baillière and Tindall

Brown J. & Shaw I., (1987), *Mental Handicap Training Profile*, CCETSW

Cameron R., Bailey M.S., Wallis J., (1984), 'Difficult and Disruptive Behaviour: 1. Reconciling needs of clients and staff', *Mental Handicap*, 12: pp. 95-97

Cipani, E (Ed), (1989) *The Treatment of Severe Behaviour Disorders*, American Association of Mental Deficiency

CNOs, (1991), *Caring for People. Community Care in the Next Decade and Beyond. Mental Handicap Nurses*, Report of the Cullen Committee, DH

Corbett, J., (1991), 'Mental Health and Disability', in BIMH (1991) op. cit. pp. 44-48

Cox, P., (1992), SEN, RMN, Department of Mental Health and Mental Illness, York School of Nursing, Personal Communication

Day, Dr. K., (1991), 'Hospital based treatment for mentally handicapped people who present challenging behaviour who are mentally ill or who offend', in BIMH, (1991), op. cit. pp. 17-19

Darbyshire P., Whitaker S., (1990), 'The Final Challenge', Nursing Times, 86:2, 66

DH, (1989a) , Needs and responses: Services for adults with mental handicap who are mentally ill, who have behaviour problems or who offend, DH

DH, (1989b), Cm. 849, Caring for People. Community care in the next decade and beyond, HMSO

DH, (1989c), Working for Patients - Working Paper 10: Education and Training, HMSO

DH, (1991), Challenges and Responses, Welsh Office

DH, (1992a), Report of Commission of Inquiry into Mentally Disordered Offenders, HMSO

DH, (1992b), The Report of the Committee of Inquiry into Complaints about Ashworth Hospital (Chair, L. Blom-Cooper), HMSO

DH, (1993), Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs (Chair J. Mansell), HMSO

DH/SSI, (1991), Caring for People. Training for Community Care: A Joint Approach, HMSO

DHSS, (1971), Better Services for the Mentally Handicapped, Cmnd.4681, HMSO

DHSS, (1979), Cmnd. 7468, Report of the Committee of Enquiry into Mental Handicap Nursing and Care, (Report of the Jay Committee), HMSO

Dorrell S., (1991), Address to MENCAP Conference, Press release

Emerson E., Barret S., Bell C., Cummings R., Hughes H., McCool C., Toogood A., Mansell J., (1987), Developing Services for People with Severe Learning Difficulties and Challenging Behaviours, University of Kent at Canterbury, Institute of Social and Applied Psychology

ENB, (1990), Framework for continuing professional education and training for nurses, midwives and health visitors, ENB

ENB, (1991), Nursing Children: Resources for Teaching and Learning, MHeNC(91)62

Hodgins P.M., Monfils M.J., (1985), 'Nursing Care and Treatment of the Retarded Mentally Ill' in Journal of Psychosocial Nursing, 23:9, 31-33.

Hogg J. & Raynes N.V., (1987) Assessment in Mental Handicap: A guide to assessment practices, tests and checklists

Holland T., Murphy G., (1990), 'Behavioural and psychiatric disorder in adults with mild learning difficulties' in International Review of Psychiatry, 2, 117-136

Jacobson J.W., Ackerman L.J., (1988), 'An Appraisal of Services for Persons with Mental Retardation and Psychiatric Impairments', Mental Retardation, 26:6, 377-380

Kiernan, C., (1987), 'Dilemmas in service provision for people with severe behaviour problems', in Segal, S., (1987) op. cit., pp. 46-47

Landerman-Dwyer S., Sulzbacker F.M., (1981), 'Residential placement and adaptation of the severely and profoundly retarded' in Bruinicks R.H., Meyers C.E., Sigford B.B., Lakin K.C. (Eds), De-institutionalisation and Community Adjustment of Mentally Retarded People', Washington DC: American Association on Mental Deficiency

LaVignia, G. W., Willis, T. J. & Donnellan, A. M., (1989), 'The roel of positive programming in behaivoural treatment', in Cipani, E (ed), 1989, op. cit., pp. 59 - 83

Letter (1989), 'Challenging Behaviour - challenging the term', Mental Handicap, 17, 1, p. 39

Lindsey M.P., (1989), Dictionary of Mental Handicap, London and New York, Routledge

Lund, J., (1985), 'The prevelance of psychiatric morbidity in mentally retarded adults', Acta Psychiatrica Scandinavica, 72, pp. 563-570. Quoted in Holland and Murphy (1990)

McManus, M. (1991), 'Credit Accumulation and Transfer Schemes', Nursing Standard, 6, 7, 1991, pp. 22-30

Menolascino F.J., Stark J.A. (Eds), (1988), Handbook of mental illness in the mentally retarded, 1984, New York, Plenum. Quoted in Jacobson and Ackerman, op. cit.

Mental Health Act for England and Wales, (1983) HMSO

Murphy G., (1991), 'Psychological treatment for People with Learning Difficulties and Challenging Behaviour who Offend, and/or have Psychiatric Disorders: Options, Outcomes and Issues", Service Responses to People with Learning Difficulties and Challenging Behaviour, BIMH Seminar Paper 1, Kidderminster, BIMH

National Boards for England and Wales, (1982) Syllabus of Training, Professional Register - Part 5, Registered Nurse for the Mentally Handicapped

NHS and Community Care Act, 1990

Newman I. and Emerson E., (1991), 'Specialised Treatment Units for People with Challenging Behaviours', *Mental Handicap*, 19, 113-119

News (1992), *Health Service Journal*, 102, 5308, p. 3.

Nihira K., Foster R., Shellhaas M. and Leland H., (1974) *AAMD Adaptive Behaviour Scale 1974 Revision*, American Association of Mental Deficiency

Oppenheim, A. N., (1966), *Questionnaire Design and Attitude Measurement*, Heinemann

Reiss S., (1988), 'Dual Diagnosis in the United States', *Australia and New Zealand Journal of Developmental Disabilities*, 14, 3, 43-48
Registrar's Letter 28/1992, *Shared Learning*, UKCC

Russell O., (1991), 'Presentation of Psychiatric illness in the mentally handicapped', *Medicine International*, 95, 2, 3975-3977

Sacks, B., 'Behaviour modification - strengths and weaknesses', in Segal, S., (1987) op. cit., pp. 48-49

Segal S. (Ed), (1987), *Mental Handicap: The Quality of Life and Behavioural Problems*, Proceedings of an International Symposium on Mental Handicap, Bulmershe Research Publication No. 8

Sovner M.D., DesNoyers, Hurley A., (1984), 'The role of the medical model in psychiatry', *Psychiatric Aspects of Mental Retardation Reviews*, 3, 12

UKCC, (1986), *Project 2000: A New Preparation for Practice*, UKCC

UKCC, (1990), *Post Registration Education and Practice*, UKKC

Walton I. & Brown J., (1989), *The Challenge of Change: Nurse Training and Education in Mental Handicap*, SPSW Publishing, ch.5

World Health Organization, (1977), *International Classification of Disease, Ninth Edition*, WHO: Geneva

Zarkowski E., Clements J., (1988), *Problem behaviour in people with severe learning disabilities: A practical guide to constructional approach*, Beckenham, Croom Helm